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CLINICAL LECTURE.

FISTULA IN ANO; LARGE SEBACEOUS CYST OF THE SCALP; LIGATURE OF THE FEMORAL ARTERY FOR ANEURISM; AMPUTATION—USE OF RELAXATION SUTURES.[1]

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(Reported by William H. Morrison, M.D.)

Fistula in Ano.

Gentlemen: The first patient I shall bring before you to-day has an anal fistula, sometimes called a fistula in ano. A false passage exists, opening by one end within the bowel, by the other on the surface of the skin near the anus. The history of this case is obscure, but probably the lodgment in one of the rectal pouches of some insoluble matter, such as a seed, for instance, has given rise to abscess, the breaking of which externally has established an abnormal channel or sinus. Sometimes very little pain results from such a condition; but this man suffers greatly, and desires relief. The radical way of affording this is to divide the bridge of tissue which overlies the sinus, and make the gap heal up from the bottom.

Not very long ago it was thought necessary always to dissect out the wall of the fistulous passage; and this is still the popular idea of the operation. Such a procedure is required in some cases in which the callous tissues bordering the sinus, which has been of long standing, would be very slow in healing. An instance of this kind occurred to me recently; the anus was nearly surrounded by a canal with very firm, almost cartilaginous walls. Under antiseptic precautions, I dissected all these away with a knife and curette, suturing the margins of the extensive wound thus produced, and then applying an antiseptic dressing.

In the present case, I pass a grooved director through the fistulous opening, and bring its point out at the anus. In order to do this, I put my other index finger into the rectum, to guide the tip of the instrument; not finding the inner orifice of the fistula, I push the end of the director through the thin wall, and now bring it out easily. I now pass a curved bistoury along the groove, and divide everything until the director is completely freed, cutting through nearly the whole thickness of the external sphincter muscle. Now (and this is a very important point) I explore the wound carefully with my finger to make sure that there are no sinuses extending in other directions. Finding none, the operation is completed by packing the wound with lint and iodoform ointment, and applying a T-bandage.

Large Sebaceous Cyst of Scalp.

This man has, as you see, a tumor about as large as an egg on the side of his head. It is what is generally called a wen, and is nothing more than a retention-cyst developed from one of the sebaceous follicles of the skin. Such tumors are often met with in this region, the scalp containing a great many sebaceous follicles. Sometimes they

[1] Delivered at the Pennsylvania Hospital.

attain a very much larger size than the one now before you.

Growths of this kind are quite harmless, but are inconvenient and unsightly. Occasionally they inflame and suppurate, and then there is danger of absorption of the products of inflammation, causing blood-poisoning. The density of the skin renders the divided veins liable to gape, and pus or even putrescent materials may be carried into the circulation. Erysipelatous inflammation, extending to the membranes of the brain, and sometimes involving the brain-substance itself, was formerly a not infrequent result of operative interference in these cases. With our present methods the danger of this sequel is set aside.

This man's scalp has been carefully shaved and rendered aseptic in the way familiar to you; and I will now divide the skin over the tumor, turn the flaps aside, and dissect out the cyst entire. There is not any bleeding of consequence. As the skin is somewhat redundant, a portion of it is clipped away; not too much, lest there should be tension upon the edges. Catgut, for drainage, is now laid in the wound; the edges are brought together and sutured with catgut; protective, iodoform, sublimate cotton and a bandage complete the dressing.

Ligation of the Superficial Femoral Artery for Aneurism.

This patient has an aneurism of the left femoral artery just below Hunter's canal; that is, just as the vessel emerges from the mass of the great adductor muscle. He does not know to what to attribute the aneurism, but has been aware that something was wrong with the part for some eight or nine months. He denies that he has ever had syphilis, or any other form of venereal disease; and while in very many cases the occurrence of aneurism is the result of degeneration of the arterial walls by syphilitic change, its existence is not at all to be assumed as proof of such change. In the present instance we may accept the patient's statement, and suppose that under some excessive strain the walls of this vessel yielded.

I shall not take up your time with a discussion of the various forms of aneurism, which will be described to you elsewhere. We have before us a dilatation of the artery, forming a tumor perhaps as large as a walnut, pulsating strongly, and giving the impression that its wall is thin. Left to itself, the wall would become more and more thinned, until it would give way, and there would be a diffuse hemorrhage into the tissues of the limb. If the rupture should take place through the skin, enough blood would soon be lost to deprive the patient of life. To prevent either of these accidents, I am going to stop the flow of blood through the distended portion of the vessel, which will become full of clot; this will organize into a solid mass. and the nutrition of the parts supplied by this vessel will be carried on by the blood flowing through the branches of the profunda. There are various ways of effecting this closure, but the one I shall adopt in this case is the tying of the trunk of the vessel where it is healthy, above its entrance into Hunter's canal.

Standing on the outer side, I begin at a point seven inches below Poupart's ligament, and carry an incision upward for three inches along the inner edge of the sartorius muscle. Drawing this muscle outward, I work down with my fingers and knife-handle, and come almost immediately upon the vessel, beating under my fingers. A small nick made in the sheath enables me to pass a grooved director under the vessel from within outward; the director is curved, with the groove in the concavity, and along the groove I carry a short, blunt, curved needle armed with the ligature, which is thus placed in position. The two ends of the ligature are now lightly closed in a single knot, when the pulsation in the tumor is found to be arrested. The knot is therefore drawn tight, and another one made, securing the vessel. Both ends of the ligature, which is of thick catgut, are cut off short; the wound is closed with sutures, catgut for drainage being first laid in it, and antiseptic dressings are applied. The limb will be, for a few days, wrapped in cotton; and the patient will be kept at absolute rest.

There are very few surgical procedures in which an accurate practical knowledge of anatomy is more essential than in the ligation of arteries. The object of the operator must be to expose the artery and apply the ligature with the least possible disturbance of the tissues. He must know where the artery is to be sought, and what its relations are to the vein or veins and nerves which accompany it. I think I have seen more difficulty encountered in the tying of the subclavian artery than in any other simple surgical operation. On one occasion I saw an experienced operator about to tighten his ligature about one of the heads of the median nerve, when a bystander asked him if he was sure it was the vessel, and fortunately the error was corrected.

Amputation—Use of Relaxation Sutures.

The case which I next bring before you is one which you saw two weeks ago. You will remember that the man had fractured his left femur on two occasions within a period of eight months. At that time I told you that I should amputate the thigh at the next clinic. Two days after you saw him, it was found that he had had some hemorrhage. I therefore decided to call a consultation as the danger of further bleeding was imminent. It was then determined that the operation should at once be performed. Since the amputation the patient has done well. You see that the appearance of the wound is satisfactory. I call your attention to the fact that we used a relaxation suture placed three inches from the edge of the upper flap and one and three-fourths inches from the edge of the lower flap. The mark which it produced can still be seen. This mark is evidence that the relaxation suture was needed and that it held the flaps together. The use of relaxation sutures in amputation wounds brings the deeper parts together and facilitates their union. It also prevents the accumulation of serum and of the products of inflammation, and obviates the risk of tension upon the superficial sutures uniting the edges.

HYSTERICAL DYSPHONIA; EMPYEMA; THE GOUTY DIATHESIS.

BY BEVERLEY ROBINSON, M.D.,

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Hysterical Dysphonia.

Gentlemen: I saw this young woman for the first time yesterday. She tried to tell me her history, but I was unable to understand her, and a friend who accompanied her had to explain what she wished to say. When asked what is the matter, she tries to speak, but it is in a very low whisper which can scarcely be understood. She spoke a little better yesterday, and also this morning. She has had loss of voice about two weeks. During that time she has had no cough, no cold, no pain in the chest, no fever. Last winter she was "hoarse" in a similar way for ten weeks, the difficulty commencing suddenly and disappearing suddenly. It is supposed that it then began with a little cold. It is extremely rare during acute inflammation of the laryngeal mucous membrane to have as complete loss of voice as this patient has. If such loss of voice occurred during an acute laryngitis there would probably be more or less cough, fever, difficulty of breathing, some noise in inspiration and expiration, and oppression over the chest. Occasionally loss of voice follows a cold, and the symptoms just mentioned are absent; but this is rare. The condition of this patient may be only nervous, that is to say, hysterical; but what that is, we do not know. On asking her whether she has a lump in the throat, or a pain in the top of the head, she says she has not; her monthly periods are normal. These facts do not point toward hysteria. She says she laughs and cries readily, but she laughs only when things please her, and cries only when injured or displeased. Some hysterical women, you know, laugh when hurt, and cry when pleased. On inquiring whether she had any great fright or strong emotion when she lost her voice, she replies that it occurred when she experienced a great pleasure. Thus it would seem that her difficulty with speech is at least partly emotional.

Incidentally I might mention the case of a young woman who had lost her voice completely for ten months. During that time she had been given cough mixtures and a variety of remedies, but her voice did not return. Recognizing her trouble as nervous, I treated her for a short period and succeeded in completely restoring her voice; she has not failed for five or six years to express her thanks annually for the service I rendered. Before I became a general practitioner I saw a good many distinguished singers for throat difficulties, and I will allude to one case in which a lawsuit had developed between the singer and her manager. The physician who had been called in had said that she was unable to sing because of congestion of the vocal cords; but he had not examined her larynx. He had only assumed that because she had lost her voice she had congestion of the cords As far as I can remember, there was no reason for supposing that there was congestion of the cords other than the loss of voice. I was called in as an expert, and on examination found the cords white, and showing no sign of congestion. Thus you will see that a positive diagnosis of congestion of the cords cannot be made without a laryngoscopic examination. I made such an examination yesterday in the patient before us, and found the cords white. But when she attempted to speak she could not bring the free margins of the cords directly

together. It would now seem that her inability to speak was due to the effect of joy; it might have been due to grief. If she had given a history of a cold existing a week or two before the occurrence of loss of voice, that might account for it. Some of the most obstinate cases of loss of voice which I have seen followed a cold, and were due to loss of power in the muscles of the larynx.

In the case before us I believe I can restore the voice at once; that I can make the patient talk by introducing this applicator into her larynx. [Dr. Robinson assured the patient she would be able to talk. On introducing the applicator down to the larynx and quickly withdrawing it, he commanded her to count: "one, two, three"; and after gentle but firm urging she repeated the numbers in a clear voice.]

I had a friend once who received a large fee by restoring the voice of a patient in this way. His success resulted only from a mental impression—the conviction being forced upon the mind of the patient that she could and would speak. Wishing to reserve this experiment for to-day, I had to give her something yesterday, and chose a stimulant for the vocal cords, consisting of:

> Tinct. benzoin. comp.,
> Ol. pini sylvestris,
> Acidi carbol. liq.,
> Tr. iodi comp. . . . . aa ʒ ii
>
> M. Sig. Use half a teaspoonful to a pint and a half of hot water as an inhalation four or five minutes every two or three hours.

Of course the patient should not be allowed to go into the cold air for a while after the inhalation. The inhalations can be made by placing a newspaper cone over a pitcher containing the hot fluid. There is nothing better to allay irritation of the larynx than compound tincture of benzoin, and to this may be added the firwood oil; but there is no necessity for the carbolic acid or compound tincture of iodine. If the patient had had acute inflammation of the larynx I should have used compound tincture of benzoin alone.

What more should I do for this patient? Well, I learned from a woman the other day that a mixture of sweet oil and mustard makes slight irritation, and can be kept on the skin over-night without distress to the patient. I think I would try that in this case, placing the poultice on the neck over-night, which would act as a counter-irritant and help restore tone to the larynx, especially to the crico-thyroid muscle. I might have put on iodine, or a plaster, or a fly-blister, but I had mercy on the patient and tried the milder measure first. But repeating a fly-blister over the neck might have a very good effect in restoring the voice, if it could not be done in a milder way. Although the measures resorted to in her case did not restore the voice, yet the general practitioner is likely to go on with their use until he loses credit with his patient and her friends. There are a number of stimulating remedies which women know about, and one will declare her ability to restore the voice, for instance, by a mixture of lemon-juice and white of egg—which might succeed, and if it did not it would do no harm—or by a piece of borax in the mouth, or a piece of nitre. An ounce of the wine of coca, or the touch of a sponge-applicator, may also succeed. If the patient had been at my office I should probably have put an astringent on the applicator before introducing it, in order to increase the mental effect. You must influence the patient's mind, and a good way to do that is to apply electricity to the vocal cords. Place a necklet around the patient's neck with a brass plate over the tensor muscle, which is the seat of one pole, while the other is applied directly to the cord by the aid of a laryngeal mirror and a strong light. Test the strength of the current beforehand by touching it to your tongue. Apply it for a few seconds until the patient chokes, then take it out, and repeat the process several times. Give a sitting every other day for a week or longer, and the voice will return and continue to grow stronger until it becomes normal. If you can not do this, then use Faradism outside, employing a mild current. Benzoic acid lozenges are of use in these cases. They are preferably made up with black currant paste, a grain of benzoic acid in a lozenge. One may be taken every hour or two.

The differential diagnosis will suggest itself to each of you. You might search for an aneurism, or for diphtheritic paralysis, or acute laryngitis. But nothing will be of greater aid to you in these cases, and indeed in the general practice of medicine, than the ability to make a laryngoscopical examination. Such examination will often be of service, and inspire your patient with confidence. In cities, it is true, there are such minute divisions of specialties that one is not expected to use all the measures of diagnosis and treatment which might be of much advantage in practice in smaller places, where it is less convenient to send patients to specialists.

Empyema.

Dr. J. B. Kennedy, of Long Island City, sent me this patient with the following note: "I first saw the patient on the 19th of last June. He had a temperature then of 104.5°, and a pulse of 120. There was pain in the right side. Three days later there were signs of fluid in the pleural cavity. I waited a day or two, then put in the hypodermic needle and drew off pus from the right pleural cavity. I then aspirated and drew off nine pints. The fluid reaccumulated, and within a week I drew off seven pints more." A few days later Dr. Kennedy made an opening into the pleural cavity and put in a drainage tube, which remained in position until a few days ago. Dr. Kennedy was good enough to send the patient to me to ask my opinion on two points: First, as to the propriety of reintroducing the drainage tube; second, if the patient will be likely to become phthisical.

The drainage tube fell out while the Doctor was dressing the wound. Is that a good indication or a bad one? I should call it a relatively good one, for it probably fell out because the pleural cavity was small—it was closing up, the tube did not pass in far, and consequently fell out. We want the pleural cavity to become closed by recession of the chest walls or expansion of the lungs, or both, and plastic adhesion of its walls. But I cannot say, until after an examination of the patient, whether or not that was the cause of the falling out of the tube. The patient says he has a good appetite, and that he has no cough; he is gaining flesh, there is no elevation of the temperature. The external opening, as you see, has closed. It was situated a little outside the right nipple—rather an unusual place for a spontaneous opening to occur. Dr. Kennedy might have seen pointing taking place there, and therefore have chosen it as the place to make his opening. Anyone can make the opening in a case of empyema, unless it is intended to take out a section of rib. Adults, as a rule, do not recover without an operation, with or without exsection of a rib.

On looking at his chest we find it is pretty well developed on the left side; the left lung should be well formed, for it has been doing more work than normal. On the right side, the walls of the chest are less retracted than would be expected from the history. I assume the reason of this is that the lung has expanded. How is that to be determined? By percussion; and yet percussion will not help much, for there is a thick membrane covering the lung arising from the pleuritic exudation. I hear respiratory sounds all over the right side anteriorly and posteriorly, but there is greater dulness beneath the axilla. Nevertheless the lung is pretty well expanded, and the rational history is good. How can we tell whether or not there is any fluid in the right pleural cavity? No man can tell positively that there is none unless he aspirates. On introducing the needle of the hypodermic syringe I am unable to obtain any fluid We conclude then that the cavity has completely closed.

Now the practical question arises, Will this young man have phthisis? There is no sign of it at present. He is gaining weight; has no cough; the pleural walls are healing up; he has no inherited history of phthisis. But you ask, Why did he have empyema? There are a good many cases in which empyema develops as such from the very beginning, and not as a result of acute or subacute pleurisy; in other words, the acute or subacute pleurisy is an empyema from the onset. It may not be possible to account for it by the history, by the surroundings and accidental circumstances, yet empyema may develop from the start. This young man says he lives in a damp house on Long Island. I have told him that he is very likely to have phthisis sooner or later unless he guards against evil habits, such as drinking, especially of bad whiskey, sitting up late, smoking tobacco, etc. Whatever else he may do, he should move into a perfectly healthy locality, where there is no malarial poison, no sewer gas, but plenty of sunlight and pure air. If he will observe these instructions for a year, and manage to keep up good nutrition, I think he will escape phthisis. But if he exposes himself in the ways mentioned, or if he becomes overfatigued, or catches a cold, he will probably be attacked at a point where there is least resistance, and it will probably be in the pleural cavity. If he again develops trouble there it will be a suppuration, and will probably end in tuberculosis sooner or later.

If his appetite fails, he should be given tincture of cinchona; if he loses flesh, cod liver oil should be administered; if tubercle bacilli are found, I should use creasote internally and by inhalation. At present I have greater faith in creasote than in any other agent in phthisis, although of itself it will not cure the disease.

The Gouty Diathesis.

This old man has gout and asthma. Seeing that other measures gave him little

relief, and learning that he had been troubled with gout, I determined to treat the latter, and gave him an alkaline mixture and colchicum; but it has apparently done him little good. He has some heart trouble, an old fibrous bronchitis, emphysema, old age, and conditions which cannot all be cured at once.

I have under my care a lawyer in comfortable circumstances, who lives a somewhat sedentary and intellectually laborious life. He had no family, and gout manifesting itself I sent him to Europe, where he spent the summer of 1888 under the care of a medical man, who told him he might return in the fall and that he would be able to pass the winter in New York without further trouble. The patient felt very cheerful after this counsel, but he had not been in New York long before he was seized with an attack of dyspnœa, which induced him to come to me. I examined him carefully all over, but could find nothing to account for the trouble. Having known him in the past, however, I was convinced that his trouble was gout. He had some dyspeptic symptoms which I treated, and with benefit for a day or two, so that he thought he was all right; but I had my doubts. Soon he returned with the same difficulty in breathing I told him I believed the dyspnœa to be an expression of the gouty diathesis, and that he needed treatment for gout. I gave him colchicin, night and morning, and after three or four days he became better, and is now feeling quite well; but he is still eliminating oxalates and urates in excess. That man had no expression of gout other than the dyspnœa, yet the latter was certainly of gouty origin and would not improve without a recognition of the gouty diathesis.

My object in showing this aged patient to you is to call attention to the fact that the underlying cause of a symptom must be reached, otherwise treatment will be unsatisfactory.

—In order to avoid acrimonious and fruitless discussions, the Glasgow Pathological and Clinical Society requires that every communication made to it shall be accompanied by a specimen of some kind (if only a pathological product, a drawing, or a patient), so that, whatever opinions and theories may be raised with reference to the communication, the specimen can always be referred to and recorded as a fact.

COMMUNICATIONS.

ON SOME MILD MEASURES IN THE TREATMENT OF INTRA-NASAL HYPERTROPHIES AND INFLAMMATIONS.[1]

BY W. H. DALY, M.D.,
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In the early part of the present decade, when American laryngology was, in a figurative, general sense, in its first short clothes, the intra-nasal structures comprised a region upon which the profession—even those of us who were then freshly budding laryngologists—rarely ventured surgically without a misgiving that we were doing something that was unorthodox. These were the days when the war-cry had not yet been sounded by the pioneers on the out-posts to attack the enemy in the nose; that here some of the chief destroyers of mankind lay hidden; that in the interior of these curled, irregular, and mysteriously arranged chambers and their more adjacent cavities, the antra, frontal sinuses, and ethmoidal cells, lurked many of the sources of fleshly ills from the myxomatous polyp to the predisposing cause of hay asthma. In these days, you will remember, our armamentarium did not include so many of the instrumental devices for working in the nose as have since been given to us by the fertility of our collaborators; and, as my lot was cast in "out of the way" Pittsburgh, where instrument makers were not convenient, much of my work upon the interior structures of the nose was done with serrated edged scissors of my own pattern. And by the way, I am very fond of using the same instruments yet, whenever I can adapt them to the work in hand. I was upon one occasion, during these earlier times, consulted by a brawny iron-worker, who complained of compulsory mouth-breathing. Upon examination I found the difficulty was caused solely by a bagging hypertrophy of the soft tissues, over the inferior turbinates, anteriorly, in each nostril. The patient said that he had hunted for my office all over the city, and insisted on having something radical done at once.

In my disposition to oblige his importunate demands, I proposed that I should with the angular serrated scissors cut off the bagging hypertrophy in one nostril, then

[1] Read before the American Laryngological Association at its meeting in Washington, D. C., Sept., 1888.

plug the cavity with a styptic cotton plug upon a piece of rubber tubing, and asked him if he could stand a little cutting, to which he answered lustily: "Yes! I am no boy. I can stand to have my head cut off." Everything in readiness, I proceeded, when at the first crush of the scissor blades, and before they had met in the tissues, the patient yelled for me to stop, and laying hold of my hands, withdrew the scissors from his nose, and then fell to the floor, fainting. As he slowly recovered from this condition, by my elevating his feet, the blood began to flow in the most alarming manner from the wounded tissues, and in this state it was with difficulty I restrained him from running out of my office. He persistently refused to allow me even to look into the cavity again.

I am not sure whether the alarming hemorrhage finally ceased from my external compression on the alæ nasi, or the exhaustion of the patient, since he would not allow me to plug the nostril. He left as soon as he could get away, with an altered mind concerning radical measures and a faded courage, but a steady determination fully expressed to have nothing more to do with me.

I never saw him again until a year or more afterward, when he fell under my care as a heritage from my colleague who preceded me in service in the medical wards of the Western Pennsylvania Hospital.

The man was then a convalescent from another ailment, and I obtained a history of his case after the operation to which I have in the foregoing lines referred. He told me that he bled from the naris more or less for ten days after the cutting, when gradually good breathing-capacity supervened in that nostril and it continued in this free and open condition, even when he suffered otherwise with cold in the head An examination was now permitted by the patient, and I found the right naris, upon which I had made the frustrated attempt at abcision, to be in a normal condition, revealing no scar or other evidence that it had ever been other than normal. Its fellow was, however, in its old condition of stenosis

To me, there was a valuable lesson in this case, which I determined to turn to an account, and to this end I persuaded the man to allow me to use similar means, of a milder nature, in the other naris. This was at last consented to, and at intervals of a few days small and deep punctures were resorted to, with a knife similar to that used for incising the cornea in the extraction of cataract. I abstracted from one-half to three ounces of blood at a sitting; and in a few weeks we were rewarded with a reduction of the tissues and an entire freedom in nasal breathing, and a cure of a permanent character.

Since then I have practised incisions and punctures in every case in which there was a contra-indication to the more radical measures which we ordinarily use. The latter cases are numerous, embracing those in which the galvano-cautery is objected to, and in which the small saw and scissors or snare are repugnant to the mind of the patient who is suffering from one of the various intra-nasal deformities resulting from or concomitant with the different stages of inflammation and hyperplasia so commonly seen connected with catarrhal diseases of the naso-pharynx. There is a class of cases, an example of which is seen in the following taken from my case-books, in which this mild measure is especially appropriate and efficacious.

Miss S. M., of Pittsburgh, referred to me by one of our New York colleagues, with catarrhal disease of the naso-pharynx. She was the only remaining child of wealthy parents, who had lost a number of grown children, and were consequently not only nervous and timid about any measure that appeared at all severe, but the lady herself was a very frail person, and subject under the slightest cause to serious fainting spells, that confined her to bed and left her heart's action weak for days at a time.

The chief but not the only cause of her naso-pharyngo-laryngeal catarrh was an extensively thickened septum, from chondritis. Upon its plane, in the left naris, the adventitious tissue filled the cavity to stenosis. The saw was forbidden, even to be mentioned, or any other of the severer measures of like nature, and only the milder incisions with the knife were resorted to surreptitiously, until the sight of blood following my examination became a thing usually looked for, and it was attended with constantly increasing benefit. I finally showed her that the innocent-looking handle, on the end of which was wrapped a piece of cotton, that I used ostensibly to cleanse the surfaces, really concealed the blade of a small knife, with which I made as many punctures deep down into the inflamed tissues as I could at each sitting, without exciting suspicion on the patient's part or producing any mental impression that would

bring on fainting. These incisions were at length known to the patient and agreed to, and the gradual but sure result was a reduction of the hyperplasia upon the septum narium, curing the concomitant catarrhal disease in the pharynx and larynx; but most of all to be noticed was the improvement in the general health of the patient.

This, gentlemen, is a type of case and the style of treatment of which I could give you a very long and somewhat varying list from my case-books; and now, after several years' experience, with this milder form of surgical measure, I bring the simple plan to your notice, believing that, even if many of you have already used it, it will not be altogether amiss for me to attest its value in this brief recital of actual experience.

THE PREVENTION OF CONCEPTION.

BY ISAAC PEIRCE, M.D.,
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There are questions which perhaps it is better for men never to discuss, questions the discussion of which will teach nothing and which should be weighed by the individual conscience and decided within the secret workings of the individual mind. But since such a journal as the REPORTER has opened the question of preventing conception, we can but believe that good will follow its discussion, and thinking men should enter the argument with minds unbiased with what has heretofore been regarded as the moral or religious aspect of the question. Moreover, if we enter this subject at all, we should do so with perfect candor, calling a spade a spade, trying to further the good of our science, and not seeking for something about which to multiply words, never reaching a conclusion. The appearance in the REPORTER of any communication on a subject so fraught with interest to physician and patient alike, invests it in the natural order of things with much weight; therefore those who undertake such communications should see that they have considered their subject well before expressing decided opinions.

At the date when I write, there has appeared but one paper on the subject since the Editorial which prompted it—that of Dr. Blackwood, who enters directly into the argument of the question and deals out facts and opinions with a fearless hand. His courage and candor deserve admiration; but I think he is too hasty in some of his conclusions and in some respects misses the spirit of the discussion, as well as the end to be accomplished. As I see it, the question suggested by the Editor was not how to prevent criminal abortion, but conception. Every man knows the horrors of illicit love and the suffering of misguided though patient and confiding women; no man is insensible to the lifelong shame of a child thrown upon the world without knowing a father; and no man denies the wickedness of criminal abortion. No medical man doubts the suffering, and in many cases permanent injury, of the woman who practises abortion that she may escape the shame of her own wickedness, sinning doubly that she may shield herself and her destroyer from the condemnation of the world. No, it takes no one to tell us this; we all know it too well; the poor creatures come to us almost every day, broken down in health, asking for treatment, asking that their secret be protected, and are willing to undergo anything to relieve their physical suffering and escape the consequences of their error. There are others known to us who are in a worse condition, those who yield to the seducer's embrace, bear their children, and, losing all respect for self, plunge into the depths of misery and disease, becoming of those to whom Mr. Leckey thus alludes in his History of Morals in Europe: "That unhappy being whose very name is a shame to speak, who counterfeits, with a cold heart, the transports of affection; scorned and insulted as the vilest of her sex, and doomed, for the most part, to abject wretchedness and an early grave, she is in every age the perpetual symbol of the degeneration and sinfulness of man; she remains while creeds and civilizations rise and fall, the eternal priestess of humanity blasted for the sins of the people."

Now, knowing the state of things as the members of the medical profession do, and having exerted every effort toward a remedy, is there a possibility of bettering these conditions by preventing conception, as Dr. Blackwood intimates? I say No! I think it can be made plain to every man that we would but bring about a worse state of affairs, if it is possible to imagine anything worse. It is true we may prevent criminal abortion, we may lessen suffering, pauperism, and neglect among children the issue of illicit love; but we do more, and we should look at this side of the question. Is it the woman, who in the hour of her fall thinks of conception? Does a preventive suggest itself to her? Does she dream that this act will

crown the love and trust she has given her seducer before the hour of its perpetration? Or is it the man, who, knowing his vows of love and marriage to be false, plans her fall and studies the question of a preventive? In eight cases out of ten, I think it is the man; and, with a sure preventive in his hands, how much stronger will be his argument, how much oftener will his persuasion meet compliance, and we all know how the falsity of his promise of marriage will increase. In the other two cases, it will require no offer of marriage, no vows of love; the desire and the preventive will be all that is required to carry them from the arms of one lover to those of another.

If Dr. Blackwod is right in teaching that a man is not culpable before the laws of God and man who interferes to prevent gestation *before* conception has occurred, as I see it, he will institute a new moral law which will be entirely different from that taught by any period of the world's history. He would make adultery a matter of no consequence so long as conception is prevented with its attendant ills. I think I am just in this view, as I think I have ground for my fear when I shudder at what would be the result of the promiscuous prevention of conception, even with the idea of stopping criminal abortion, pauperism, and suffering of illegitimate children. I believe that if we put into the hands of men a ready and sure means of preventing conception, there will be more prostitutes, fewer marriages, and more disease among women. Syphilis, gonorrhœa, and chancroid will be the next in order requiring a preventive.

I think this is the idea which has kept the question in the dark so long, and not the fear of how moralists and church people would receive it. It has been the fear of instituting a process which we could never hope to control, and which would in a short time become so universal and popular as to admit of no check, that has made cowards of the medical profession. I think we have been cowards heretofore, and the REPORTER will deserve much credit if this discussion should determine for us clearly the questions: Should we ever prevent conception? and, if so, when should we interfere? What is a ready and sure means of effecting the object? and how shall we keep the matter in our own hands? No physician should give a preventive to be used outside of the married state, any more than he should produce abortion for the sake of shielding either mother or father. And if we confine ourselves to married life, a vast number of men, both in and out of our profession, will take the ground that, child-bearing being the natural consequence of matrimony, it would always be wrong to interfere; that a woman who incurs the risk of pregnancy and childbirth should bear it as best she may, never crying out, no matter how great her suffering, always allowing her husband his "rights"; and if she fill a premature grave they would consider it a sad fate, but a fate from which there is no escape. Then, a large number of women who have safely passed their menopause are prepared to laugh at the suffering of their younger sisters, and would look upon any interference as criminal. The younger ones would show a majority on the other side, and some, as in Dr. Blackwood's case, will cry out that suicide is preferable to another pregnancy and delivery.

Assuming that there are cases—and I think few men in the medical profession will not admit that there are cases—where the prevention of conception would restore the happiness of a family, give peace to the wife, turn the husband again to the path of virtue, and prevent the life-long suffering of offspring; then the question arises, what are these cases? Dr. Blackwood is right in claiming that there is no justice in condemning children to an inheritance of syphilis, scrofula, tuberculosis, epilepsy, or imbecility, and he might have added a host of others. Where this is to be avoided, I agree with him that prevention is *imperatively demanded.* Again, women who are deformed, women whose lives are made one constant and heavy burden by pregnancy so often repeated that they seem never to have an end, women who are made miserable by the so-called "habit" of abortion, and women whose former gestation and delivery have brought them almost to the door of eternity and who are now in constant dread lest another such ordeal will complete the work and leave a motherless child or children—yes, all these women who are crying out to us from the depths of their fear and misery for help should be heard and their prayers answered. There is no other way. Men *will not* abstain from sexual intercourse, though they see their trusting wives gradually slipping from them, and if here and there one is found who yields to the entreaties of his wife to spare her from a horrible death and a premature grave, he will most often be one who is damning his own soul, ruining his life, and saving the woman from one evil only to render her more unhappy by gratifying his lust among harlots.

Recognizing the fact that there are cases in which prevention is a necessity, and that our duty is to work a reform that will prevent much of the physical suffering and mental distress among women, I am at a loss to know what are the means best suited to accomplish this and how to apply them. The number of preventive measures which have been proposed is not small, but the selection of one which we can control and its restriction to those alone who really need it are not easy. Let it become generally known that the medical profession countenances a preventive even in a few cases, and there is reason to fear this will be stretched to a license which will work much mischief to women who are already experimenting in this direction, who have no reason why they should not fulfill the God-given function which makes happy homes, and who are now only held in check by the judgment of the world. Will it not also place in the hands of men a ready argument with which to destroy the purity of loving, trusting girls? As I see it, this is the reason why to the deserving as well as the undeserving we have for so long given the old woman's advice, "to take a glass of cold water before going to bed and *nothing else*." This is the reason why we have allowed women to lead lives of misery and seemed not to heed their cries for relief. Thoroughly awake to the fact that the prevention of conception is sometimes right, that it is sometimes a plain duty, it is to be hoped that we may yet find some means whereby we can overcome the difficulty of the problem and confer a blessing on those who will appreciate it most.

A CROP OF BOILS.

BY WILLIAM M. CAPP, M.D.,
PHILADELPHIA.

Quite a number of articles have recently appeared in the medical journals concerning furuncle. Each writer had his favorite "sure cure," and one might feel that there was cause to reproach himself as blameworthy if he did not at once abort, cure, prevent recurrence and avoid a "crop of boils" in any case of the kind which should present itself. Lately an opportunity offered itself to me to try some of the remedies advised. A patient about seventeen years old came for treatment for an unmistakable boil upon the thigh—large, inflamed, swollen and painful. The general health was good and at first only local applications were resorted to. Mindful of the theory that succeeding boils come from external inoculation from a previous one, the greatest cleanliness was observed and boracic acid disinfection was used. A liberal application of a salve composed of salicylic acid rubbed up in simple cerate was made at bedtime, and though it caused smarting at first, afterward it was soothing, and a good night's sleep was obtained. In the morning there was a large accumulation of matter, which was removed without much pain; but the skin in many places around, where it had been covered by the salve. was blistered as thoroughly as if cantharides had been used. The hardness was all gone, there was relief from pain and very soon there were the appearances of a healthy sore which healed satisfactorily. But a few days later as many as nine other points of pain and induration were noticed, all within a radius of five inches from the site of the first boil. The same application but with a smaller proportion of acid, and with cosmoline substituted for the cerate, was used. The boils all quickly suppurated with very little pain. Most of them were superficial; two only were at all large and none of them were as formidable as the original boil. They were thoroughly cleansed by a solution of bi-borate of soda and dressed with cosmoline of neutral reaction, having boracic acid rubbed into it in about the proportion of twenty grains to the ounce. Some cosmoline has an acid reaction, and hence is irritating and for such applications is better avoided. This treatment proved soothing, at once allaying the itching and soreness, and a rapid healing followed with no further irruption in that locality.

A few days later several inflamed pimples appeared on the face and the general health appearing a little depressed, an iron tonic was administered and also sulphide of calcium, four times daily in a dose of three-quarters of a grain, which was gradually increased to a grain and a half. One of the pimples becoming large and painful, another of the remedies recommended as infallible was tried upon it, viz.:—tannin made into a paste with tincture of arnica and gum acacia, painted thoroughly over and around the affected spot. It certainly was soothing, but otherwise worthless, unless indeed it may have hastened suppuration; for, the next morning the boil discharged copiously.

By this time several angry lumps were developing, with much pain, on the cheeks and one on the chin. As there were still other treatments recommended as never

failing to abort a forming boil, it was thought desirable to try some of them. The chin was freely and frequently bathed with a solution of salicylic acid—the part kept moist with it. It was soothing, but the boil suppurated at three points, with probably less swelling and pain however, than otherwise might have been expected. A strong solution of boracic acid in alcohol, which was much praised by a recent writer, was tried upon another forming boil, with quite similar effect.

The two upon the cheek which threatened to be very troublesome were treated according to the recommendation of still another writer. They were painted freely for three days with the semi-fluid extract of belladonna, at the end of which time they had nearly disappeared without suppuration and were practically well. The application from the first was soothing and the result satisfactory.

In addition to the treatment narrated the patient took at the solicitation of friends as a vaunted household remedy for boils, some porter—a wineglassful four times daily for three or four days. After about four weeks from the appearance of the first boil, there were no further manifestations and the malady seemed passed.

It is in order now to decide if any of the remedies had any effect whatever upon the disease except to mitigate the pain at the time. The writer feels that in treating another case of furuncle, unless meanwhile a better course should commend itself, he would rely upon calcium sulphide internally and belladonna externally, and would hope for like good results.

Since writing as above, an acquaintance relates that quite recently in treating a case essentially similar, the medication used was the fluid extract of burdock internally, with equally good results. This remedy then, in his estimation, is also to be added to the list of "sure cures."

—Prof. Heinrich von Bamberger, of Vienna, Austria, is dead.

—The *Northwestern Lancet*, Nov. 1, 1888, says that the mortality from fever among the workmen on the Panama canal has been greatly reduced by the establishment of proper hospitals for the care of the sick, and a convalescent home on one of the islands in Panama Bay. It is said that as the result of these measures workmen no longer stand in dread of the fever, and are flocking to the work in immense numbers.

SOCIETY REPORTS.

NEW YORK ACADEMY OF MEDICINE.

Stated Meeting, November 1, 1888.

The President, A. JACOBI, M.D., in the chair.

DR. J. LEWIS SMITH read a paper on

Sudden Heart-Failure in Diphtheria.

Physicians of experience, he said, commonly meet with cases of diphtheria which seem to be progressing favorably; the medical attendant and the relatives of the patient feel cheerful at the bright prospect of recovery, when suddenly the scene changes, symptoms of dangerous heart-failure appear and usually result fatally. In the more favorable cases active stimulation may cause the patient to rally, and perhaps to recover; but often another attack occurs and ends in death. The most complete clinical history of sudden heart-failure in diphtheria has been given by Cadet De Gassicourt. In some cases the symptoms develop more gradually. In the first class the patient's pulse is likely at first to be slow, then becomes rapid, the respiration superficial, the surface pallid, perhaps slightly cyanotic, the patient utters cries of agony, and soon dies. or perhaps rallies under stimulants, but succumbs to a subsequent attack. In the second class of cases death is less sudden; there is no agonizing cry or moaning at the last moments. Some, perhaps the majority of patients, manifest disturbance of the stomach, epigastric pain, vomiting, dyspnœa, rapid respiration and heart-beat. De Gassicourt has recorded but one recovery in fourteen cases A careful microscopical examination has been made in three cases, including an examination of the pneumogastric nerve and myocardium, which were normal in one case; in all three the medulla oblongata was apparently normal, but the gray matter of the cord which had no immediate connection with the affected heart contained degenerative changes. Sudden loss of power in the heart has been attributed to several causes; for instance, to changes in the muscle of the heart; to thrombosis or antemortem clots in the heart; to disease of the central organ of innervation, the medulla oblongata; to deficient conducting power in the pneumogastric; to the influence of ptomaines.

Recent observations have not borne out the view that endocarditis is the cause of the

cardiac failure; its existence has not been proved. A more probable theory of the cause is that granulo-fatty degeneration occurs, a change which is present in some cases, but can account for only a few.

Cardiac thrombosis has been regarded as a cause by Beverley Robinson and by French writers, but it has since been shown that the clots are identical in appearance and kind with those found after death from other diseases; they occur during the death-struggle and are secondary to heart-failure. The theory of deficient innervation is most applicable to the majority of cases. On this theory also one can account for vomiting, epigastric pain, and interference with respiration—the lungs, heart, and stomach being supplied by the same nerve, the pneumogastric.

The facts, Dr. Smith thinks, justify the view that there is a cardiac paralysis. What is true regarding the nature and cause of palatal and multiple paralysis is probably true of cardiac paralysis. He advanced objections to the view that the cardiac failure is due to peripheral neuritis; when the neuritis exists it need not be the sole cause. As to disease of the central organ of innervation, he said it has not been demonstrated. The mutability of the paralysis, its disappearance and reappearance in the same muscles, conflict with these views of its origin.

A theory regarding the etiology of diphtheria and its symptoms which is rapidly gaining ground is, that the specific germ acts locally, and that the systemic infection takes place through ptomaines the product of such germs. Treatment must be prompt and with active remedies. The patient should be kept quiet in bed, the head low. Alcoholic stimulants should be administered, and concentrated and peptonized food be employed; hypodermic injections of brandy should be given during the sudden seizure. Other useful agents are: ammonia, camphor, musk, the electrical current. Subsequently, remedies employed in diphtheritic paralysis of other forms may be used. Some have spoken very favorably of strychnia.

The PRESIDENT thought the paper suggested the following points for discussion: Is heart-failure occurring early in diphtheria of the same nature as that occurring late? Are the cases with a slow pulse identical with those with a rapid pulse? Are the cases following general paralysis the same as those preceding it?

DR. A. L. LOOMIS said he had made a post-mortem examination in but one case of diphtheria with death from heart-failure. The right cavity of the heart was much dilated, its walls flabby and granulo-fatty. He had supposed that sudden heart-failure in diphtheria did not always depend on the same cause. His impression is that in the acute stage of the disease it results from the diphtheritic poison, whatever that may be, just as heart-failure sometimes occurs from the poison of typhus fever. In other cases he said he had rather yielded to the opinion that it is due to a peripheral neuritis.

DR. CAILLÉ said he had formerly advised patients with mild diphtheria to be out some, and take light exercise in the fresh air, but one patient having had heart-failure under such circumstances he now always advises the patients to remain in bed. One of his patients brought on heart-failure and death by taking some indigestible food. He advises in all cases of diphtheria, rest in bed, proper food, and stimulation.

DR. BEVERLEY ROBINSON referred to his investigations regarding diphtheria while he was in Paris a number of years ago, when he made many post-mortem examinations and found heart-clot of a nature to convince him that it was antemortem and the cause of death. He has not had reason to change the view then formed. He raised the question if the common free employment of tincture of the chloride of iron may not be a cause of such ante-mortem heart-clot.

DR. FRUITKNIGHT leaned toward the view that ptomaines, the product of microbes on the surface, are the toxæmic agent and cause of heart-failure in diphtheria.

DR. SEIBERT said he would differentiate between heart-failure from the effects of the diphtheritic poison on the central nervous system in the acute stage of the disease, and that occurring later and usually in gangrenous diphtheria.

Dr. Dessau made some remarks, and Dr. Loomis combated the view of Dr. Robinson as to heart-clot causing death. He expressed the belief that such clots develop during the death-struggle which is caused by heart-failure.

The PRESIDENT mentioned anæmia of the brain as one cause of sudden death in diphtheria, as it is in other diseases which leave the patient in a weak state. He also said that in some cases the heart-failure may have received the credit of causing death when really paralysis of the respiratory muscles has been the occasion of it. He suggested the freer use of alcoholic stimulants in diphtheria; he thinks there is little likelihood of their too free administration.

Dr. Smith, in closing the discussion, suggested that cases in which the patient, almost moribund from heart-failure, is rallied for several hours or a day before having another attack followed by death, are against the theory of heart-clot, as, indeed, are cases of multiple paralysis.

Reports of Clinics.

Bellevue Hospital.

MEDICAL CLINIC—PROF. LOOMIS.

Gout.

Case I.—The patient was a man, 42 years old, a barkeeper by occupation, and a well-nourished and healthy-looking man. He was brought before the class with the history of having been acutely sick for four days. In speaking of his history to the class, Dr. Delafield said that he gives no family history of gout. He has always been a drinking man, indulging in all sorts of drinks, averaging twelve to fifteen a day. He has been also a hearty eater, eating rich and nutritious foods. For many years he has not taken any active exercise, none at all out of doors. His first attack came on about fourteen years ago. In previous good health, he awoke one morning to find the great toe red, swollen, and very painful. These symptoms increased for the first few days, the pain being most severe at night; and then these signs subsided, leaving him perfectly well. The duration of the attack was about one week. He remained in good health for about one year, when he was again suddenly seized with an illness similar to the one just described. The same joint was affected: the acute signs lasted, as before, four or five days, but the toe remained stiff and tender, and he could not go about well for nearly two months. After this, the attacks increased in frequency; other joints became affected—the fingers, elbows, knees, shoulders and hips; and, during the interval between the acute exacerbations, he was never entirely free from stiffness and soreness in certain locations. At the present time, there is a typical swelling at the knuckle of the index finger of the right hand, and also at the joints of both big toes.

This, then, is a characteristic case of gout. The one exceptional feature it presents is the fact that there is no history of hereditary taint. Gout is a disease that is almost always hereditary, and further, that usually requires more than one generation for its development. A gouty parent is certain to give the gouty diathesis to his children. But in this patient there is no such history, and we look to the fact that he has been almost all his life in-doors, eating largely and drinking largely—especially of wines and ales—to find the cause of his disease. A man cannot develop gout in one generation on wine alone: it can occur only in those who eat more than they can assimilate, and at the same time do not take sufficient exercise.

Dr. Loomis asserted that one-third of those listening to him at the Clinic ate more than they could assimilate, and, as in the patient, this excess is taken up by the blood. In the present case, uric acid is generated, and in the joints urate of soda deposited, and this must occur unless exercise uses up this excess from the food. Dr. Loomis does not believe in the existence of rheumatic gout; the disease is either the one or the other, rheumatism or gout. A patient may have an attack of rheumatism, and later on he may also have gout, but there is no combination of the two diseases.

Gout, as it becomes chronic, in all cases, as in this one, makes its victim a cripple. In an acute attack, the first change in a joint is the deposit of urate of soda on the fringes and edges of the cartilage; accompanying this there is hyperemia, etc. At first, these deposits are removed after the attacks, but later on they remain and thus incapacitate the joint. Similar deposits may occur all over the body, and may be seen in the joints, skin, ear, eyelids and elsewhere. The present case he believes to be the earliest in regard to development he has seen in non-hereditary gout. Where this tendency is strong he has seen the disease manifest itself in children of five and six years of age. In this patient it began, as it always does, in the big toe. As is almost always the case, this patient has refused to give up his mode of living. He loves his table and he seasons his food highly. The gouty subject is a *bon vivant*, and it is always a pleasure to dine with him. In this lies the difficulty of weaning these people from this active cause, over-feeding. In the treatment of these cases little can be expected from local applications; but the limb should be well elevated, and colchicum should be given. It is to this drug that entire treatment is trusted. It will not cure gout, but it will relieve an attack, and that is all. It makes these chronic cases worse. These sufferers pin their trust to some one preparation and

carry it about with them, to be taken on the first appearance of an attack. In this way an attack can be often warded off. There are Laville's Liquid, Blair's pills, White's pills, and a host of other remedies, among which is the one that this patient has had faith in, namely, Loomis's Acetic Extract of Colchicum.

Dr. Loomis long ago found out that there is but one preparation of colchicum which is of very much value in acute gout, and that is the acetate of colchicum. Laville's Liquid used to be employed in England and elsewhere for years in preference to every other drug in these cases. None relieved so rapidly and completely. This was due to its containing, as the chief ingredient, this acetic extract of colchicum. This drug will certainly relieve, if carried far enough—it should purge sharply two or three times—in this manner the capillaries of the portal circulation are unloaded. To assist in this effect other drugs can be added. Loomis's preparation before mentioned contains also aloes, ipecac, and calomel. Dr. Loomis suggested the following gout pill:

℞ Ext colchici acetici,
Ext aloë,
Pulv. ipecac.,
Hydrarg. chlor. mit. . . . . aa gr. i
Ext. nucis vom. . . . . gr. ¼ ad ½
M Sig. Ft. pil. No. I. To be taken every four hours, until it purges.

These pills may be carried about and employed at the first sign of an attack: they will often abort it.

After the attack is over, the real treatment begins. Medicines are now of no avail. Iron does harm. Cod liver oil is not usually well borne.

Our dependence is on diet and exercise. On the question of diet the profession is divided. One-half say, Give the starches and no meats; the others, No starches, but green vegetables and meat. Dr. Loomis believes it makes but little difference, and employs in his own cases a mixed diet; but it must be very sparing, attention being directed to the thorough assimilation of all that is eaten. To achieve this purpose the patient must be half starved: he should always rise from the table hungry. His wines and his high living should be stopped. If for any reason stimulants should be required, spirits is the best form to use. Active exercise in the open air is also of vital importance. He would advise this patient on his recovery to become a cow-boy.

Having occupied so much time on this first case, there remained but sufficient to present the second and note the chief distinguishing features between the two.

Rheumatism.

Case II.—The patient was a man, 35 years old, a worker in a gas-house, where he is exposed to sudden variations of temperature. This patient was attacked suddenly several days ago: his right hand is now much puffed up and red, his left wrist is also affected, and there is some pain and swelling in the right shoulder. He gives no family history of rheumatism. He is a moderate drinker, and this is his first attack.

Briefly, the differences between this case and the preceding one are these, and they are characteristic: Rheumatism never begins in the smaller joints, and in one attack joint after joint will become affected. The reverse is true of gout: it begins in the smaller joints, and does not pass from one joint into another. Rheumatism is liable to give acute endo- and peri-carditis. Gout is not likely to, but it may develop slowly an interstitial inflammation of the peri- and endo-cardium.

The subject of rheumatism has been under the influence of damp and wet, or as in this patient, of sudden variations in temperature: the gouty subject gives a long history of no exercise and hearty feeding. And it is just here in the etiology that is found the greatest difference between the two diseases. A person of this patient's age will probably have some cardiac complication before his attack is through. On examination, a murmur was discovered with the first sound of the heart.

These cases of endocarditis usually leave a crippled heart behind them.

—The *Quarterly Journal of Inebriety*, October, 1888, says that the Count de Villeneuve was tried at Hyeres, France, for selling wines adulterated with arsenic. It seems several persons, noted wine drinkers, had died, having many symptoms of arsenical poisoning, and others were made very ill. The wine used was found to be heavily charged with arsenic to hold it from change, and was the direct cause of the death and illness. The trial was for damages by the friends of the victims, but the prosecution failed. The judge condemned the process of wine adulteration and the case ended. A curious sequel to this event followed in September last, when the Count de Villeneuve gave thirty thousand francs indemnity, and two plantations, to over two hundred of the sufferers who had drunk this wine.

SPECIAL CORRESPONDENCE.

JOTTINGS FROM AROUND THE WORLD.

The University of Melbourne.—Examination Questions.—Boarding Houses for Students. Visit to a Lecture-Room.—Law Against Immoral Literature among the Fiji Islanders.

MELBOURNE, Sept. 10, 1888.

My travels have been so extended, since beginning the "Jottings from the Occident," that I feel compelled by longitudinal reasons to change my title; and as I propose to complete the tour of the world, *via* Indian Ocean, Red Sea, England, New York, and finally San Francisco by the way of the Isthmus of Panama, it will be more appropriate to name these papers as above. I trust I can jot down such medical items as, gathered by a physician in his wanderings, will be of interest to many. It has been gratifying to me, and also shows the wide circulation of the REPORTER, that a number of letters have reached me from doctors all over the country asking fuller particulars of some points touched upon, especially in regard to California. It will give me pleasure to answer any questions.

Australia is no longer in the occident; the English include this country in the orient; but it is the dividing line between the occident and the orient—Honolulu is in the far occident to them, and Melbourne in the far orient.

University matters in Melbourne are of sufficient peculiarity and interest to make this letter deal almost entirely with them. There is a flourishing medical school in this city, a department of the University of Melbourne. The corner stone of the University was laid in 1854; the medical department was formed in 1862. The grade of study is a high one; since 1872 no student can obtain credit for any portion of the medical course unless he first has passed an examination in Greek, Latin, English, arithmetic, algebra and geometry. The course continues five years, and the student must pass five examinations during this time; then, if successful, he obtains the degree of Bachelor of Medicine or of Surgery, as the case may be. The examinations are both written and oral. A graduate from any recognized school of medicine may obtain the University degree after passing the fifth-year examination. Candidates for the degree of Doctor of Medicine or of Master of Surgery must be Bachelors of Medicine or of Surgery of at least two years' standing in the University of Melbourne or in some other University recognized by it. I wish that space would admit of making an extended list of questions asked at the fifth-year examination. I shall give simply a specimen in each department: "What are the effects on a pigeon of removing the whole of the cerebral cortex?" "Give the minute anatomy of the œsophagus." "Describe the macroscopic and microscopic changes which occur in acute bronchitis." "Write a commentary on adenomata." "Describe all the structures that bind together the bodies of the vertebræ from the axis to the sacrum." "Describe the steps of the dissection necessary to expose the inferior dental nerve." "Compare the hearts of a frog, a fish, and a mammal, and make a sketch of each." "Dissect the nervous system of a crayfish." "How may aldehyde be prepared?" "What are the different forms of cannabis Indica?" "Discuss the dietary of acute febrile disease." "Enumerate all the appearances of drowning, twenty-four hours after death." "What are the diseases that may produce cavities in the lungs?" These questions are for what are called the ordinary examinations; if any student enters for an honor examination, a separate set of questions is used and is correspondingly more difficult.

A word as to the building itself. Both the University building and the medical hall are unattractive—rather musty, ivy-grown affairs that would look all right in England, but are not quite up to our modern ideas in newer countries. The grounds are, however, very large and very pretty, being adorned with flowers, trees of all kinds, and an artificial lake.

The professors can neither sit in Parliament, nor become members of any political association, nor can they give private instruction, nor receive any persons, whether students or otherwise, as boarders in their houses. A curious feature is the license required to be obtained by all who desire to keep a boarding house for students. Those desiring to obtain a license must make an application in writing, accompanied by the certificates of two or more resident householders in Melbourne (one of whom must be a member of the Senate of the University, or a justice of the peace) as to the character of the applicant. On the receipt of such an application the Registrar inspects the house of the applicant, and reports to the

Chancellor as to the situation and neighborhood, the accommodation, the state of repair, and the general fitness of the house for the purpose, and any other remarks he may consider for the interest of the University. Upon the payment of one pound the successful boarding house is granted a license for one year. Any breach of conduct on the part of this house will result in a revoking of the license or a refusal to renew it. How many of our poor boys in Philadelphia would like a plan like this. I think many fewer "*mysteries*" would be served up at dinner. And what glorious fun to hint, in the most dignified tone of voice, that an immediate change must take place in the *menu* or "we shall tell on you." And still more, as I am writing this, my doctor-friend beside me says, the house thus under the ban of the college is published in the most prominent paper of the city.

I had the pleasure, a few days ago, of taking luncheon with the Dean of the Medical faculty, Prof. H. B. Allen, and of hearing two of his lectures on anatomy and pathology. The Doctor's life has been a University one; first as student and graduate, then as lecturer, demonstrator, professor and dean. He is only about 40 years of age, but the present status of the medical department is largely due to his faithfulness to its interests. The salary of the professors amounts to about five thousand dollars, and a house free. A new house has been completed for Dr. Allen in the grounds and next to the school. The money for all University purposes is voted by the Victorian Parliament; only a few private bequests at present have been received. The Professor says that while there is no direct law against private practice, they find that accepting a chair is equivalent to retirement from practice; the duties are so many and so continuous, by reason of the graded courses, that it is impossible to do anything but University work. A Chair is not the stepping-stone to practice here; quite the reverse. The position is made to compensate for this in two ways; first, by making the position a sure one—a professor can be removed only on the showing of gross misconduct, and he can demand reasons of removal, even before the Supreme Court if he deem it best; and, in the second place, after fifteen years' service a very handsome extra is added to his salary, on the ground that by this time his services in practice would be yielding a larger income.

A few minutes before the Professor arrived I entered the arena of the lecture room in company with Dr. Gillam, a recent graduate of the University of Pennsylvania, who is out here in charge of a patient of Dr. S. Weir Mitchell. We found that medical students are the same the world over, as we were received with most hearty applause, on the simple basis of anything for a noise and a racket. But on the entry of the Professor, instantly the most profound quietness prevailed, making a strong contrast to some of our similar occasions at home, where the unbounded delight of the professor seems to be to hear the greatest commotion on his appearance. There was a dignity and respect in this instant hush that impressed us.

In front of each seat is a table for note taking, which is insisted upon. The lecture was on the anatomy of the spinal cord, and was most excellent, showing that the lecturer was a true teacher; self was entirely hidden and the sole effort was to make clear the subject in hand. There was not the slightest hint of personality, all was for the one object—teaching. After the hour was over the Professor retired for a few moments, during which time an advanced class had assembled in the same room to hear the lecture on Pathology, the subject being heart diseases. In this lecture the doctor spoke very slowly, and waited for each word to be taken down. At the close of each lecture the roll was called and absentees marked; an average attendance of eighty-five per cent. being required. After the close, I took the opportunity of making a further interview, and learned the additional facts that the average number of graduates is twenty-five a year, usual attendance one hundred and fifty; no native Australian has ever taken the degree; the clinical service is not in a satisfactory condition; no clinics are held in the University grounds, the students attending the Melbourne hospital. In this line Prof. Allen is striving to make some reforms and advances. While a foreigner must be impressed with the thorough and exacting theoretical courses, he can readily see that our country is far ahead in clinical teaching. The clinic room is scarcely ever the preparatory process for higher professional position, therefore it is not so eagerly sought after. The diplomas of only such colleges as have a positive three-year graded course are recognized here; it is not sufficient to show that the applicant has studied medicine for three years. A case in point has just been before the Registration Board. An American claimed the right to practise on account of having taken an extra year a few years after his regular two-year

course in one of our best colleges; his claim was rejected.

There is no chair of Sanitary Science as yet in the University, but steps are being taken now to create such a one, and the Government has indicated its willingness to furnish the money. The Government is very liberal to its University; Prof. Allen says that he received word a short time ago that, the budget being in a satisfactory condition, they would like to know how much money he wanted for the next ten years for the University; he named a goodly and increased sum over the usual amount, and it was at once voted.

The great Centennial Exhibition which is going on here now, while of the grandest proportions and showing the rapid growth of a most wonderful country, is not of sufficient medical interest to cause any special remark on my part in a medical journal. There is nothing on exhibition that is specially new in our line; in the American Court the medical display consists of several notorious patent medicines, and throughout there is a dearth of any worthy medical exhibit. For reasons given in a former letter this would have been a favorable opportunity to show these people anything of a sanitary character—systems of drainage, etc., etc.

Fiji islanders and skull soup seem to be closely associated in one's mind, the readings of school days having fixed the cannibalistic tendencies of these people in the memory. What will you think when I tell you that, quite recently, the authorities of these islands confiscated some of Naphey's books, as being literature calculated to spread immorality? I am personally acquainted with the man who tried to import them; he was arrested, his books taken out to sea beyond the coral reefs, and dumped into the ocean; he was saved from imprisonment only on the promise that he would never do such a thing again. Some of the poetry of this "goody goody" is taken away when we know that the very prosecutor in this case lives down the island with three or four black wives. One of the officials who obtained a glance at one of the books, with an imagination fired by the fuss made over the matter, determined to have one at any risk; he made known his want to my friend, who took his revenge on the Fijians as follows: he had one of the books unbound, and then had it rebound with the attractive title of "A Family Dictionary of the English Language"; it passed the customs as such in safety, and the official is happy.

PERISCOPE.

Angioma of the Forehead.

The *Revista de Ciencias Medicas*, of Havana, August 20, 1888, contains an account of a case of angioma of the forehead which was successfully treated by electrolysis. The patient, who was under the care of Dr. Raimundo Menocal, was a little girl 2 years old. The tumor, which was of the size of a large filbert, was smooth and soft; it was of violet color, and could be reduced by steady pressure. It had appeared soon after birth, and was growing gradually larger. Elastic compression had been tried without result. On August 6, Dr. Menocal applied electrolysis, introducing the needles in various parts of the tumor, but always with the points toward the centre of the mass. The application, which was continued for three minutes at a time, was repeated every three days. The tumor was somewhat diminished in size after the first sitting; at the fourth, eschars were observed about the negative pole, which were thrown off a few days later. This was followed by a little suppuration, but there was no hemorrhage. At the date of the report no trace of the tumor remained except a few tiny scars.—*British Medical Journal*, September 15, 1888.

Hysterical Neurosis of the Stomach.

J. Schlesinger (*Wiener med. Blätter*, No. 3, 1888) communicates the case of a young girl who suffered with disturbance of the stomach which was diagnosticated ulcer, although there was no hæmatemesis. She recovered completely under a milk treatment rigidly carried out. One year subsequently the patient was again taken sick, with violent pain in the stomach, loss of appetite, nausea, vomiting, and complete sleeplessness. No kind of food could be borne, and the largest doses of morphine, even when administered subcutaneously, had not the least effect. The diagnosis of ulcer of the stomach was then made. It was learned, however, that in the boarding-house in which this patient lived was a girl affected with hysterical neurosis of the larynx, and that in a short time two other young girls, including the patient, became similarly affected. A diagnosis of hysterical neurosis of the stomach was then made, the patient put upon bromide of sodium, and complete recovery soon occurred.—*Centralblatt f. d. med. Wissenschaften*, Sept. 1, 1888.

New Use for Bergeon's Method.

We learn from the *Wiener med. Presse*, August 26, 1888, says that Givre has recently communicated to the *Lyon Médical* a very interesting case which suggests a use for Bergeon's method of rectal insufflation of gas that may prove of more practical value than the one for which it has heretofore been used. It seems that a lad fourteen years old was attacked on May 23 with obstinate obstruction of the bowels, accompanied with vomiting of fæcal matter and colicky pain in the umbilical region. As the condition remained unchanged on May 28, the patient was brought to the hospital Hôtel Dieu, where his symptoms were found to be enormous meteorism, small pulse, superficial rapid breathing, temperature 101.3°, fæcal vomiting, violent colicky pain, and obstinate obstruction of the bowels. After copious irrigation, washing out of the stomach, and the constant current had been employed in vain, the rectal injection of gas according to Bergeon's method was tried. The tube was inserted into the rectum to the extent of fourteen or fifteen inches, and the gas injected under very high pressure. When the belly could be distended no further and the contour of the inflated coils of intestine was clearly visible, the patient was seized with violent pain and the tube was withdrawn. The patient had at once a desire to go to stool, and passed with a loud noise the enema of gas, and then from six to eight quarts of yellow, stinking fæcal masses. The patient has since been well.

Aneurisms of the Aorta.

In a communication to the Academy of Medicine of Paris, August 13, 1888 (*Gazette Hebdomadaire*, August 17, 1888), Germain Sée stated that he had had in his practice twenty-four patients with aneurism. He has noticed that these patients very often become tuberculous and die of a phthisis which is characterized by cavities and a progress that is slow and non-febrile. This fact seemed to him interesting from the point of view of the pathogeny of the disease in these patients.

In speaking of the action of the iodides in aneurism, M. Sée expressed the opinion that they have a definite action (1) upon the dyspnœa of secretory origin, by liquefying the product of the catarrh; (2) upon the intra-pulmonary circulatory troubles in hyperæmia of the lung, by checking venous stasis; (3) upon the size of the tumor, by contracting its walls and the tissues surrounding it. As a result of the diminution in size of the tumor, the pressure effects are relieved.

The Percussion Limits of the Stomach.

In a paper in the *St. Petersburger medicinische Wochenschrift* on the boundaries of the stomach and intestinal canal, by Dr. P. Jaschtschenko of Rostoff on the Don, the view of Traube and some other anatomists, that the stomach when empty falls back and does not lie in apposition with the abdominal or chest wall, is controverted; and so is his belief that the fuller the stomach is the lower its inferior border lies. According to Dr. Jaschtschenko's observations, the inferior border of the transverse colon extends as far downward as the umbilicus; the superior border, which is 2¼ inches higher, lies at a distance of 1½ inches below the sternum. When the gut is quite empty, the inferior border lies a little higher, or ⅓ inch above the umbilicus. In the right and left hypochondriac regions the superior border passes under the costal arch, being covered on the right side by the lower border of the thorax and the lower border of the liver, and on the left by the lower border of the thorax only. If the left half of the transverse colon and the upper part of the descending colon are full, the stomach being empty, a more or less dull percussion sound will be obtained over the lower part of the thorax on the left side, but above this there will be a tympanitic note up to the inferior border of the lung. If a part of the colon is empty, the stomach being full, a dull note will be obtained over the stomach, and a tympanitic note over the transverse and descending colon—that is, when the individual is in a standing or sitting posture. When he is lying on his back there will be a tympanitic note all over, with the exception of course of the region of the spleen. It is known that the superior border of the stomach lies against the lower border of the left lung, its inferior border coinciding with the transverse colon. This never changes its place, the filling of the stomach causing the dulness to extend from below upward, not from above downward, as Traube thought. Again, the stomach when empty does not collapse and fall back, for it is always under these circumstances distended with air. After death, in consequence of the loss of tone of the diaphragm, the abdominal organs rise somewhat above their position during life.—*Lancet*, August 18, 1888.

Temperature and Pulse During Menstruation.

In the Russian weekly *Vratch*, No. 35, 1888, Dr. Alexander V. Repreff, of St. Petersburg, writes that he has carefully examined the temperature and pulse before, during and after menstruation in 49 healthy and sick women, and that he has arrived at some important results of great interest both to the physiologist and to the practitioner. The outcome of Dr. Repreff's laborious observations (varying in duration from 11 to 42 days, with 4 measurements daily) may be briefly given as follows:

1. Healthy Women. There were 10 of these; 8 girls, from 15 to 27 years old; and 2 women, 41 and 23 years of age. Both the temperature and pulse during menstruation were found to fall below the average figures as observed in the same subject during the intermenstrual period. For a day, or several days immediately before and after menstruation, both the temperature and pulse manifest a rise above the intermenstrual average figures. This rise, however, never reaches a febrile height, which circumstance is said to be a characteristic feature of a normal condition of things. The said variations of the temperature are invariably strictly parallel with those of the pulse. The rectal varies with the axillary temperature, which constitutes another characteristic sign of the woman's local and general healthy state.

2. Sick Women. Of these there were 39. In women suffering with chronic uterine affections, the temperature and pulse during the catamenia rise above the individual normal level. In some cases, however, there are observed falls during the first and last day of the bleeding. In women suffering from oöphoritis and salpingitis, the temperature and pulse rise up to a febrile height immediately before and after, but oscillate about the normal level during menstruation. The rise is especially high in cases complicated with recent peritoneal inflammation. In women suffering with a mass of morbid processes simultaneously, the temperature and pulse present irregular oscillations. The parallelism between the thermic variations and those of the pulse is often absent in morbid cases. The same may be said in regard to the rectal and axillary temperature: sometimes, the axillary temperature and the pulse fall, while the rectal temperature rises. In a woman with amenorrhœa of three months' standing, there was observed, at regular intervals of four weeks, a rise of the pulse and the rectal and axillary temperature above the individual standard, which lasted on every occasion four days, and coincided with the appearance of lumbar pain, mucous discharge from the uterus and mucous diarrhœa.

3. The general conclusions are: 1. Menstrual variations of the temperature and pulse in healthy women are characterized by certain constant and typical features. 2. The latter disappear as soon as the woman falls ill. 3. Hence, under certain conditions, the menstrual temperature and pulse may serve as a diagnostic means for determining the state of the woman's sexual apparatus. The indications of the kind are especially valuable in cases of more or less latent sexual affections, such as a gonorrhœal disease of the internal sexual organs. 4. The behavior of the temperature and pulse in connection with menstruation gives an additional proof in favor of the view that the process is a general systemic one (and not local only), as Andrëëff, Rabutôt, Goodman, Mary Putnam-Jacobi, Stephenson, Carl Reinl, Hegar, etc., think and teach.

Vomiting of Pregnancy.

In connection with the case of a pregnant woman who suffered with uncontrollable vomiting, but who refused to have abortion induced, and died within twenty-five days, Jaffe, of Frankfort, makes some remarks upon hyperemesis gravidorum (*Volkmann's Sammlung klinischer Vorträge*, No. 305). He divides the vomiting of pregnancy into three classes. In the first, vomiting occurs only in the morning on an empty stomach; this is the most frequent form and the prognosis of it is good. In the second, which is not rare, vomiting occurs in the morning and also during the day after taking food, though only a part of the food is vomited. In this form the appetite is good, and the nutrition is not altered. With the occurrence of the movements of the fœtus the vomiting disappears. The third form, uncontrollable vomiting, is rare. It begins with the occurrence of conception, or first appears later. It is undecided whether it is more frequent in primiparæ or in multiparæ. The etiology is not known. If the affection is called a reflex neurosis, still this is only a definition that says nothing. The course of the disease exhibits three stages. In the first stage all nourishment is rejected; there is no fever, but thirst, pain in the epigastrium, salivation, and often constipation and anæmia, together with emaciation. In the second stage there is slight fever, the tongue is dry, and there is pain in the

epigastrium. The expired air is foul-smelling, the urine is concentrated and contains albumin and casts, which are the result of a nephritis produced by the inanition. The emaciation and the failure of strength increase. In the third stage high fever persists, delirium occurs, the patient sinks into a sleepy condition, and dies.

The diagnosis presents no difficulty. In the differential diagnosis diseases of the stomach and neuroses are to be considered. The prognosis is very uncertain; it is influenced both by the period in which the hyperemesis occurs, and by the life or death of the fœtus.

Treatment by diet and with medicines is generally ineffectual; the best agents are opium and the bromides. If local affections are present, a treatment directed to them is at times effective. If other measures fail, the pregnancy is to be interrupted—but not if the third stage has been entered upon, for in this case the patient is irretrievably lost.—*Wiener med. Presse*, September 9, 1888.

Action of Methylgreen in Checking Coagulation of the Blood.

In *Virchow's Archiv*, September, 1888, there is a paper by Professor A. Mosso, of Turin, on the employment of methylgreen for the recognition of the chemical reaction and of the death of cells. He finds that the methylgreen hinders coagulation of the blood. A solution of five-tenths per cent. methylgreen in a seventy-five hundredths per cent. salt solution retards coagulation of the blood considerably, even though only thirty minims of it are used to eleven fluid drachms of blood. If fifty or sixty minims of the solution just mentioned are added to eleven fluid drachms of blood, coagulation no longer occurs.

The leucocytes in blood that has been rendered uncoagulable by means of methylgreen are in their substance uncolored, while in their interior the so-called nuclei are stained emerald green. In some, the green substance is diffused throughout and fills the whole blood corpuscle; other leucocytes, on the contrary, are completely colorless, but the greatest part of the blood-corpuscles is violet, without a trace of so-called nuclei.

If eighty or ninety-five minims of a five-tenths per cent. solution of methylgreen are mixed with eleven fluid drachms of blood which has been drawn directly from the arteries, the methylgreen can easily be seen to be decomposed. Microscopic examination proves that the intensity of the coloration of the blood corpuscles and of the serum does not correspond with the quantity of methylgreen mixed with the blood, and that many leucocytes remain white. If acetic acid is now added to this blood, no matter in what proportion, and the blood is then diluted with water, the characteristic green color no longer persists. This shows that the disappearance of the green color can not be ascribed to the alkalinity of the blood. Prof. Mosso assumed that methylgreen in contact with blood is decolorized by an oxidation process; he then set to work to determine if the same phenomenon could not be brought about in some way by peroxide of hydrogen. The results obtained fully established his previous supposition.

The Fumes of Ether for Tinnitus Aurium.

In a paper read before the Cincinnati Academy of Medicine, September 10, 1888 (*Lancet-Clinic*, Sept. 29, 1888), Dr. J. E. Boylan reported a case of tinnitus aurium in which great improvement had followed the use of the fumes of sulphuric ether, which were insufflated through the Eustachian catheter. The patient was a man 40 years old, who had had chronic otorrhœa since he was a boy. After the first application of the ether very carefully carried out, the patient returned much elated; the noises, previously almost continuous, had ceased shortly after the application, and remained away for six or eight hours. After the second application they remained away for twelve hours, and when they returned they were of a much milder character. They continued to yield to the treatment, and the patient obtained a rest at night such as he had not known for a year. In order to satisfy himself that it really was the ether vapor that was benefiting the patient, Dr. Boylan substituted water upon two occasions; but this change was followed, in both instances, by a complaint that the noises had been severe and almost ceaseless. Upon another occasion, when the ether in the bottle used had become almost exhausted, the treatment had very little effect; but after replenishing the bottle, the good results were again immediately manifest. Dr. Boylan says he has now been treating the patient for over two months; his general condition is much improved; the noises, which are only discernible at intervals, are slight and of a totally different character (ringing). He pursues his vocation, which is that of a painter, and is very careful never to miss treatment.

Poisoning with Benzoate of Sodium.

In the *Centralblatt f. d. med. Wissenschaften*, July 21, 1888, Dr. K. A. H. Mörner, of Stockholm, communicates a case of poisoning with benzoate of sodium, which he thinks is the first hitherto reported. It seems that in the hospital of Sabbatsberg, at Stockholm, a patient was operated on for an ovarian cyst (dermoid), but the cyst could not be removed. Its contents, however, were evacuated and more than three ounces of benzoate of sodium, with some naphthaline, introduced into the sac. Some thirty hours after the operation symptoms of poisoning occurred. The patient sank into a condition of confused delirium, alternating with a sleepy condition; these symptoms passed away after a few hours. On the following day they returned in a milder form, and then staid away. The temperature during this time was 98.6° to 102.4° F. Perspiration did not occur in an important degree. There were no convulsions, but only trembling of the hands. The pulse was small, 120 to the minute.

As soon as the symptoms of poisoning appeared, the cyst was washed out with water. The urine which the patient passed after the first appearance of the poisoning was sent to Dr. Mörner for examination. The latter describes it as moderately dark, reddish-brown, and becoming somewhat darker. It showed a slight green fluorescence. The reaction was strongly acid; the specific gravity 1026; albumin and peptone were not present. It reduced an alkaline solution of oxide of copper and oxide of bismuth; but owing to the small quantity of urine it was not determined whether or not this reduction was due to the presence of sugar. The color of the urine was not due, as was at first supposed, to the naphthaline that had been used, but to the presence of a large amount of urobiline. Naphthaline was also excluded as the cause of the poisoning. On the contrary, the belief that benzoate of sodium was the cause of the poisoning seems to be completely justified, for the urine contained very decided quantities of hippuric acid, which upon the addition of hydrochloric acid crystallized out in such quantities that the fluid was almost filled with the needle-like crystals. Two quantitative estimations of the hippuric acid (one according to the method of Bunge and Schmiedeberg, the other according to that of Meissner) gave 28.68 grains and 29.43 grains respectively in about three ounces and a quarter of urine. In the efining of the hippuric acid with rhigolene only a little was extracted—1¼ grains. The rhigolene solution left behind a resinous residue, from which Mörner did not succeed in obtaining crystals of benzoic acid.

In spite of the large quantity of benzoic acid absorbed no unchanged benzoic acid was excreted. Meissner having declared that benzoic acid may be changed in the organism into succinic acid, the urine was investigated for the latter, but with negative result. The amount of nitrogen in the urine was pretty high—9 grains in about 3 ounces, which, after subtraction of about 2½ grains belonging to the hippuric acid, makes the nitrogen correspond with 46½ grains of urea in about 3 ounces of urine; it seems to him not improbable that the excretion of urea was increased, as Salkowski had found to be the case in the dog after the administration of large quantities of benzoic acid.

Dr. Mörner says that in a small portion of urine which was passed two days later he could not find any hippuric acid.

Removal of Tattoo-Marks.

The removal of tattoo-marks has always been considered a very difficult feat. Many methods have been recommended at various times, a pretty sure sign that none of them is very satisfactory. Dr. G. Variot, of the Paris Biological Society, has recently proposed a new process, which he declares to be invariably successful in removing blue and red tattoo-marks. Without hazarding an opinion beforehand, one must admit that the method is based on apparently sound principles. But it is, perhaps, well here to remark that Dr. Variot is attached to the central infirmary of the Paris prisons, and therefore in excellent position to experiment with such disfigurements, since, for some inscrutable reason, criminals, who have most to fear from identification, are just the men who most often brand their persons with indelible marks. Dr. Variot operates as follows: The tattooed parts are first wet with a concentrated solution of tannin, and with a set of tattooing-needles the skin is punctured all over the colored portions to the depth usually adopted by professionals. All the parts tattooed with tannin are next rubbed over with the lunar-caustic pencil, the silver salt being allowed to act upon the epidermis and derma until the needle-pricks have turned a deep black. The excess of liquid being now wiped off, things are allowed to follow their natural course. The whole surface treated will soon turn black. The pain, quite moderate during the operation, continues to be slight for the first two

days, and is accompanied with some local inflammation. After the third or fourth day no more pain is felt, and, except for large marks, no dressing will be necessary. After fourteen or eighteen days the eschar will fall off and leave, instead of the tattoo-marks, a reddish superficial cicatrix, which will gradually turn paler, and, after two months, almost disappear. On close scrutiny it will probably remain always perceptible, but it will otherwise be scarcely noticeable, and, at all events, the skin will show no trace of the former emblems, more or less artistic. In explanation of the remedy's mode of action, Dr. Variot thinks that the coloring-matter forming the tattoo-marks is generally localized in the upper third of the derma, the deeper portions remaining unaffected. On tattooing at first with tannin, the solution penetrates exactly to the same depth as the foreign particles, and, acting as a mordant for the silver nitrate, enables the caustic solution to permeate the derma to the proper depth and no further. Hence the skin will preserve its elasticity, and the scar be so little apparent. Before finding out the foregoing process, others were unsuccessfully tried on prisoners, at their request, and it may not be useless here to briefly point out their imperfections. Blisters, even kept up some time, proved entirely insufficient. They do not reach deep enough. Red-hot iron was found unmanageable and dangerous, too short an application being useless, and too long a one leaving painful sores and ugly scars. As to tattooing with a number of blistering or caustic solutions, including silver nitrate, they were scarcely satisfactory, although coming nearer the mark. Their main fault was that they were exceedingly painful, even when the punctures were not deep enough. But when tannin was first applied, and then lunar caustic, the results were all that could be desired.—*Therapeutic Gazette*, September, 1888.

Lead Poisoning in Domestic Animals.

The Paris correspondent of the *Therapeutic Gazette*, September, 1888, says that the effects of chronic lead-poisoning on man are well enough known, but the way domestic animals are affected under the same circumstances is not so well known. And yet a better knowledge of the symptoms would often be of some usefulness, as it would supply a clue to the cause of obscure epidemic poisonings. An interesting contribution to this branch of toxicology has been incidentally supplied by Dr. Cornillon, one of the physicians and chemists delegated to investigate the poisoning cases which not long since occurred at Gannat, near Vichy. The lead was introduced into flour through the ignorance of a workman, who had plugged with white lead a defective millstone in a mill which used to grind all the village corn. Of course the plumbic carbonate dropped off, got mixed with the flour, and poisoned nearly every one around. Among human patients the symptoms were, with a few exceptions, the customary ones. But domestic animals, fed with the same bread, afforded very curious symptoms. In some families the dogs became so restless and barked in so fearful a manner and so ceaselessly that their masters, thinking them mad, had them killed. Chickens simply died; hens bore the poison better, but stopped laying eggs. In one farm, after all the family had been sick, they had quite a quantity of the poisonous flour left, and tried to feed it to pigs. But three of the animals, which were sold soon after, died at the buyer's, and the three others first refused to eat for several days, and finally died. Their gums had the characteristic blue tinge, and obstinate constipation was observed, indicating saturnine paralysis. Another particularity worthy of remark was that, while hens ceased to lay, menstruation troubles among the Gannat women were unusually prevalent.

Extract of Pancreas in Atrophic Catarrh of the Stomach.

Dr. Reichmann, of Warscham, at the meeting of the Congress of Polish Physicians and Naturalists, July 18–22, 1888, said that atrophic catarrh of the stomach, so called because of the atrophy of the glands of the stomach and consequent lack of gastric juice which are present, was a very disagreeable form of disease of the stomach for the physician to treat. Glands that have become changed anatomically cannot be regenerated. Dr. Reichmann has observed the disease ten times in one hundred and seven patients with disease of the stomach. As neither hydrochloric acid, nor pepsin, nor other agents introduced from the outside were of assistance, Dr. Reichmann tried alcoholic extract of pancreas (12 to 15 per cent.) and pancreatine, and was convinced that digestion of the food, which before remained stagnant and coarse, was rapid and complete. The symptoms of the disease changed quickly, and the general condition of the patient improved in a pretty short time.—*Wiener med. Presse*, September 9, 1888.

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EDITOR AND PUBLISHER.

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THE PERILS OF THE PHYSICIAN'S LIFE.

Among the usual vicissitudes of the physician's life are fatigue, anxiety, and exposure to disease; weariness of body and severe mental strain; and at times distrust, ingratitude, or even calumny. Besides this, on occasions which are fortunately rare, the physician is exposed to the brutal rage of jealous or unreasoning men, and his errands of mercy may lead him into great physical danger or even to death.

An illustration of the extremest outcome of the faithful discharge of the physician's duty has recently been reported from Georgia, where, on October 21, 1888, Dr. J. B. Manson, one of the most eminent, skillful and benevolent physicians of that State, lost his life as the result of a brutal assault made upon him by the father of a child he was treating for typhoid fever. No reason is assigned for this inhuman act, except that the perpetrator of it may have been insane. Be this as it may, he fell upon the benefactor of his child with the fury of a madman, and, with violently abusive language, beat him so cruelly that he died within three days.

This occurrence exceeds in horror anything which we can now recall among the unfortunate experiences of medical men. It surpasses in barbarity even those instances—of which there are not a few—in which physicians have been decoyed from their homes with a tale of suffering, in order that they might be waylaid and robbed; and it brings forcibly to mind the perils of a calling which often calls for a degree of courage and devotion which our fellow-men sometimes seem to forget.

Fortunately, as we have said, such extreme instances as this are of rare occurrence; but unfortunately instances of lesser danger are not uncommon. There is probably no medical man of much experience who could not narrate stories of imminent peril to his life, incurred solely because he followed the path of duty without flinching from its risks; of the dangerous rise of passion in the hearts of men inflamed by suspicion or brutalized with drink; of scenes of violence or of crime to which his professional duties led his feet; of outcasts or desperadoes to whom he had ministered at his own peril. In addition to this, who among us has not again and again risked his life in the care of persons suffering with contagious diseases, while those whose bereavement he was endeavoring to avert watched him with distrust and repaid him with ingratitude?

These are the hardships of the physician's lot—these and the labor and anxieties which

go with them. In looking at this side of his experience, one sometimes wonders that so many men are found, day by day pursuing their ministry of mercy, unquailing, uncomplaining, and asking no special recognition of their heroism. Into the haunts of vice of great cities, and the lairs of desperadoes on the edges of civilization, they go; into rooms reeking with infection and towns where epidemics rage; and ever they bear with them a spirit of self-sacrifice which has few parallels in mortal experience. Such, we rejoice to know, are the men who by thousands cover every civilized land with their ministry of mercy, and make up the grand army of healers.

Once in a long while—as now—some startling occurrence attracts the attention of the community to the character of their work; and then, for a little, they may find some appreciation of its hardships, and a cessation of the carping criticism to which they are often subjected. In the main, however, they cannot look for any such consideration to support them in the discharge of their duty, but rather to the principles of fidelity and humanity which are their surest and most constant reliance. "*Fortiter, fidelite*" is their motto; and "*feliciter*" is their reward when only it can be attained.

INHALATION OF CARBONIC ACID IN DYSPNŒA.

It certainly seems like "setting a thief to catch a thief" when we find it recommended to give inhalations of carbonic acid to relieve dyspnœa, and yet at a meeting of the Academy of Sciences in Paris on February 27, 1888, Dr. Edmond Weill spoke very highly of this very procedure. In a number of cases of laryngitis and advanced phthisis he had administered by inhalation from two to four quarts of carbonic acid gas, once or twice a day. The effect was to cut short paroxysms of dyspnœa, if the inhalation took place when a paroxysm was in progress; and if it was made between the attacks the respiration became much more free, and the paroxysms became less frequent, shorter and less severe. The same results were observed after inhalations of carbonic acid gas in attacks of dyspnœa in emphysema with albuminuria. Dr. Weill compares the effect of these inhalations with that of hypodermic injections of morphia.

This curious therapeutic method seems so contrary to all preconceived notions of the physiology of respiration that it would require some courage to adopt it. But it is well known that morphia will often do more good by diminishing reflex irritation, than harm by obtunding the respiratory centres; and it is by no means unreasonable to suppose that carbonic acid gas may do more good as an anæsthetic than it will do harm as a poison. It would be interesting and instructive to have some confirmation or correction on this side of the Atlantic of Dr. Weill's views in regard to the value of inhalations of this gas in dyspnœa; for if it can accomplish here what he has claimed for it, it may be a very valuable addition to our therapeutic armamentarium.

TREATMENT OF RETROFLEXION AND PROLAPSE OF THE UTERUS.

At the last meeting of the Association of German Naturalists and Physicians, Dr. Adrian Tchücking, of Pyrmont, read an interesting paper which is published in the *Deutsche med. Wochenschrift*, October 4, 1888, and in which he described and advocated a novel method of correcting retroflexion and prolapse of the uterus. His method consists in drawing the uterus forcibly downward, and passing a ligature through its cavity and substance and then through the vaginal wall, so as to fix the womb in a position of extreme anteversion.

To do this requires a needle and holder of peculiar construction, a certain dexterity, and the observance of careful aseptic precautions. The result has been very satisfactory in the twelve cases in which he had,

at the time he read his paper, carried out his method. The uterus, soon after he removed the ligature, assumed a perfectly normal position, and the troubles dependent upon its former malposition disappeared in most of the cases.

Dr. Tchücking's description of the method is not quite as full and complete as we might wish, and he does not describe the instrument he uses at all. But, so far as his paper goes, it seems to indicate that his method is not difficult of execution, that it is quite free from danger, and that it accomplishes excellent results. Under these circumstances it certainly deserves the attention of gynecologists, and we hope it may prove a useful addition to our resources for the treatment of conditions which are a cause of much suffering to women, and which often tax severely the skill and ingenuity of their medical attendants.

THE AMERICAN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

At the time when the first Congress of American Physicians and Surgeons was meeting at Washington, the first gathering was held of a society to be called the American Association of Obstetricians and Gynecologists. This organization is intended to give greater prominence to the study of obstetrics than it has had in any of the existing national societies, and to blend the study with that of gynecology. The proceedings at the first annual meeting were very interesting. There was rather too great a preponderance of gynecological subjects on the programme; but the papers were excellent and the discussions were very instructive.

The idea of having an Association largely devoted to Obstetrics is a good one, and we hope this one may prove a valuable addition to the number of national associations which have of late years done so much to advance the science and art of medicine in the United States.

THE PHYSICIAN'S POCKET RECORD.

Last year we announced the preparation of a new and thoroughly revised edition of the POCKET RECORD published at this office, which has so long been a favorite with the Profession.

Inexperience in this work, however, led to our being disappointed by the printer, and when the Pocket Record came out, it had been delayed so long that many of our subscribers had to turn to other sources.

This year we have made better arrangements, and we shall have a new edition ready in good time. We therefore beg our readers to send in their orders now (without money) for Pocket Records for 1889. As soon as the books are ready, we will notify those whose orders we have received, and they may remit payment then.

The price will be: One Dollar for a Pocket Record for thirty patients a week and $1.25 for a Pocket Record for sixty patients a week.

The books for 1889 will be printed *with dates*. Orders for books without dates (perpetual) will be taken; but we think most medical men prefer the dates printed in the book.

We have on hand some of the last edition of books without dates and will sell them for fifty cents each, if the money is sent with the order.

BOOK REVIEWS.

[Any book reviewed in these columns may be obtained upon receipt of price, from the office of the REPORTER.]

A TEXT-BOOK OF HUMAN PHYSIOLOGY. By AUSTIN FLINT, M.D., LL.D., Professor of Physiology and Physiological Anatomy in the Bellevue Hospital Medical College, New York, etc. With three hundred and sixteen figures in the text and two plates. Fourth edition, entirely rewritten. Large 8vo, pp. xvii, 872. New York: D. Appleton & Company, 1888. Price, cloth, $6.00.

It is not necessary to say much in announcing the appearance of the fourth edition of this magnificent work, which has already taken rank as one of the most learned and most practical treatises on physiology in the English, or any other, language. The present edition includes the most recent advances in the science of physiology, and in remodelling and rewriting the work the author has used excellent

discrimination as to what should be omitted, what retained, and what added to the contents of the earlier editions. We are glad to note also that his book is not filled with pictures of complicated and multiplied apparatus, and that the illustrations found in its pages are instructive and useful. It need hardly be added that they are beautifully executed.

There is so much which might be said in praise of this book that we have little inclination to criticise it; but we would have been glad if the author had included in it a chapter on teratology, although this may have been omitted on the ground that it belongs rather to pathology than to physiology. Again, it would be interesting to find some reference to the very curious assertions in regard to fecundation after castration of the male, such as we laid before the readers of the REPORTER, in an Editorial in the issue for May 19, 1888.

Other matters which they would like to see discussed will doubtless occur to those who study Dr. Flint's book carefully; but, on the whole, it is remarkably complete, and will not disappoint any reasonable expectation. Its literary and scientific value is very great, and its mechanical execution is equal to the best that comes from the excellent publishing house which has issued it.

A TEXT-BOOK OF PHARMACOLOGY, THERAPEUTICS AND MATERIA MEDICA. By T. LAUDER BRUNTON, M D., D.Sc., F.R.S., Assistant Physician and Lecturer on Materia Medica at St. Bartholomew's Hospital, etc. Adapted to the United States Pharmacopœa (*sic*) by Francis H. Williams, M.D., Boston, Mass. Third edition. 8vo, pp. l, 1261. Philadelphia: Lea Brothers & Co., 1888. Price, cloth, $5.50; sheep, $6.50.

This book has already been long enough before the medical profession to require little more than the announcement of the appearance of a new edition to attract the attention of our readers. The present edition has the same merits of fulness and clearness which its predecessors possessed, and bears the same impress of the individuality of the author. It has been revised so as to devote more attention to certain subjects which have undergone rapid development during the last few years, although it has not caught up with the most recent data in regard to such drugs as antipyrine, used as a nervine; calomel used as a diuretic; sulphonal; etc. So much could not, of course, be expected of a book requiring so much time for its printing as this one has required; and with extremely few exceptions, we believe it presents a very accurate view of the present state of knowledge in regard to its subject. A noticeable feature of this book is its very complete index of remedies, and a helpful index of diseases and the medicaments which may be used in the treatment of them.

LITERARY NOTES.

The first number of the *Maritime Medical News*, a bi-monthly journal, published at Halifax, Nova Scotia, has just appeared. It contains twenty-six pages of reading matter and six pages of advertising. Its size is 11¼ x 8¼ inches. The subscription price is $1.00 a year. Its contents are interesting and well edited, and it gives promise of usefulness. We share the conviction of the editors that there is room for a journal published with special reference to the professional interests of the Maritime Provinces of British America, and heartily wish this one success.

NOTES AND COMMENTS.

Carbonic Acid Water as a Vehicle for Creasote.

The taste and odor of creasote are so disagreeable to many patients that physicians have in some instances been deterred from prescribing it, especially in the large doses in which it has been advised by German writers. It is true, when given in capsules the taste and odor are not perceived; but this form of administration is objectionable when large doses are given, because the drug then reaches the stomach in a concentrated form. In the *Berliner klin. Wochenschrift*, August 6 and 13, 1888, Dr. J. Rosenthal advises the use of carbonic acid water containing cognac as a vehicle for the creasote. This combination, he says, is comparatively tasteless and obviates the disadvantages attending the administration of creasote in a concentrated form. The mixture is put up in bottles holding five and a half, ten and a half, and sixteen ounces. The smallest bottles contain from one and a half to three minims of creasote and seventy-five minims of cognac; the middle-sized bottles, six minims of creasote and two and a half fluid drachms of cognac; while the largest contain nine minims of creasote and three and a half fluid drachms of cognac. During the first week the patient is directed to take one of the smallest bottles after dinner and supper each day; during the second week he should take a half bottle of the next stronger water after breakfast and dinner, but continue to take the weaker water after supper. The quantity of creasote which he takes may in this way be increased gradually until the maximum dose of twelve and a half minims a day is reached.

Antipyretic Action of Phenacetine.

Dr. Armin Huber reports, in the *Correspondenz-Blatt für Schweizer Aerzte*, No. 18, the experience with phenacetine as an antipyretic, gathered from Prof. Eichhorst's clinic in Zurich. Phenacetine is without odor and taste, and as it is insoluble in most diluents, it was administered shaken up in some water or wine. In by far the greatest number of cases it was given in doses of fifteen grains, and only once a day. Apyrexia began in a few hours, with profuse perspiration. If the drug was given in the later hours of the forenoon, the period free of fever amounted to from five to seven hours and over. Phthisical patients remained

without exception free from fever the whole day. The increase of fever as a rule occurs slowly. The pulse often does not diminish in frequency with the fever, but remains high, though its tension is markedly increased. Collapse was never observed. The patients have no disagreeable feelings as the result of the action of the drug. Vomiting never occurred. In a few cases there was no exaltation of the subjective sensations. Huber calls attention especially to the fact that phenacetine acts as an antipyretic in all febrile diseases—in tuberculosis, typhus fever, polyarthritis, peritonitis, ulcerative endocarditis and fibrinous pneumonia. In a girl seventeen years old, with pneumonia of an upper lobe in the stage of hepatization, the temperature was brought down to normal from 102°.3 with fifteen grains of phenacetine. In a girl eighteen years old, suffering with polyarthritis, antipyrine was given in clysters to the amount of sixty grains a day for two days; the temperature on the first day fell about a degree. On the second day of taking the antipyrine, the temperature before taking it was 103°, after taking it 102°.3, and it soon again rose to 103°. Phenacetine was then given (fifteen grains) and on the first day the patient was free from fever for four hours. On the third day, when she took two doses of about sixty grains, she was without fever the whole day.

Huber considers that phenacetine is an antipyretic preferable to antipyrine.—*Wiener med. Presse*, October 21, 1888.

Causes Determining the Creation of the Sexes.

Charpentier says it seems that the absolute or relative age of the parents has a certain influence upon the production of the sex of the embryo, and so have both the more or less pronounced degree of sexual vigor of the father, and the moment at which the egg has been fecundated after its expulsion from the ovary. It seems to be established with sufficient clearness that, when the man is ten years older than the woman, while she is at the period of highest sexual activity, more boys than girls are born. Moreover, the fecundating element which is most energetic from a sexual point of view, possesses the property of engendering more individuals of its own sex. Finally, when coitus is practised slowly after menstruation (eight days at least), the production of boys is favored. The general proportion is 106 boys to 100 girls.

Bidder, whose researches have been based upon a total of 11,871 confinements, arrives at the following conclusions:

1. Very young primiparæ beget more boys. 2. Primiparæ in middle life, that is to say, at the time of full generative vigor, beget more girls. 3. After this latter period has been passed, they beget more boys. 4. The results are the same in multiparæ, but the age at which the diminution of the number of boys appears occurs a little later.

It would seem, according to Bidder, that the sex of the child holds to the male or female quality of the ovule. Male ovules will be more numerous and more likely to be fertilized in early and in advanced age. On the contrary, during the period of full generative vigor of the woman, female ovules are more numerous and more likely to be fertilized.—*Bulletin Médical*, Oct. 17, 1888.

Johns Hopkins University.

In an article in the *Independent*, Oct. 25, 1888, President Gilman says, among other things, that Mr. Hopkins left a large sum to found a hospital, with the intention that the university should establish a medical school in connection therewith. The hospital buildings are now completed, and the university has already established three professorships as the beginning of a medical department. "The only cause for anxiety in the future of the Johns Hopkins University," says President Gilman, "is the suspension of dividends by the Baltimore and Ohio Railroad. The founder gave the university fifteen thousand shares of the common stock of the railroad, and he recommended the trustees in the most explicit terms to keep, protect, and defend this investment." The income from this stock has been about $150,000 a year, and has been the main support of the university; and, now that it has ceased for a time, there is little to sustain the institution except the tuition-fees and the moderate surplus that has been accumulated in past years. President Gilman suggests that the friends of the university should make up an emergency fund to relieve its present needs, and expresses confidence that such an institution as the Johns Hopkins University "will not long be allowed to suffer for the want of an income." This confidence we believe to be justified; and certainly every lover of learning will hope that a university of so much promise may suffer no check in its useful career.—*Science*, Nov. 2, 1888.

Do Library Books Spread Infection?

A good deal of discussion having taken place on the subject of the spread of infectious diseases by means of the books in circulating libraries, the Dresden municipal authorities have had a thorough experimental investigation of this question conducted. A number of much-used volumes from the town library were taken for the purpose. The dust from the leaves and covers was sown in nutrient media and cultures reared, the result being that no microbes belonging to infectious diseases were found—the dust being, in fact, nothing but ordinary dust of a harmless character. Again, the dirtiest leaves in the books were rubbed first with the dry finger and then with the wet finger. In the first case scarcely any microbes were found on the finger; in the second case plenty were found, but all appeared to be of a non-infectious character. Especially is it noted that there were no tubercle bacilli. Lastly, books were soaked for two days in spirit containing 10 per cent. of carbolic acid. This treatment destroyed all the bacilli, and proved harmless to the volumes. The conclusion arrived at was that the danger of circulating libraries spreading infection is very slight; but a recommendation is given to dust books well before reading them, and never to wet the finger in the mouth for the purpose of turning over the leaves.—*Lancet*, Aug. 18, 1888.

Traumatic Subdural Abscess of the Brain.

Sir William Stokes, Professor of Surgery in the Royal College of Surgeons, Ireland, concludes a paper in the *Dublin Journal of Medical Science*, October, 1888, with the following deductions.

1. That after the primary symptoms of cerebral traumatism have subsided, there is frequently a latent period of varying length, during which there are no distinct brain symptoms whatever connected with abscess formations.

2. That their appearance is, as a rule, sudden, and if uninterfered with they run a rapidly fatal course.

3. That the occurrence of pus production resulting from cerebral traumatisms is not incompatible with a perfectly apyrexial condition.

4. That this latter fact will probably aid in differentiating traumatic cerebral abscess from meningeal or encephalic inflammation.

5. That both as regards color and consistence there is great variety in the contents of cerebral abscess cavities, and that, as shown in Wilm's case, published by Rose, of Berlin, they may become transparent.

6. That antisepticism has largely diminished the risks of the operation of trephining.

7. That, having regard to the great mortality of cases of cerebral abscess when uninterfered with—viz., from 90 to 100 per cent.—the operation is indicated even when the patient is *in extremis*.

8. That, in the case when the trephine opening does not correspond to the situation of the abscess, exploratory puncture and aspiration may be employed.

9. That by the adoption of this measure the necessity for multiple trephine openings can be largely obviated.

10. That the employment of a blunt-pointed aspirating needle, as suggested by Rentz, is probably the safest mode of exploration and evacuation.

11. That drainage is desirable in the after-treatment of such cases.

12. That both during and subsequent to operative interference in these cases a rigid antisepticism is imperatively required.

Valves in the Veins of the Human Intestines.

Dr. W. S. Bryant's conclusions are: "These observations show that at birth the valves in the intestines are quite numerous in man, and at this age they are more abundant in the large intestine. Also that in a few months the valves either disappear or become incompetent, with few exceptions. In adult men there are usually a few valves, and these are more abundant in the small intestine, especially in the superficial tributaries of the venæ breves. These valves are more numerous in the jejunum, and disappear as we approach the cæcum.

"Though the valves just described were discovered since Hochstetter's paper was written, his remarks on the significance of valves in the portal system will apply to them. After alluding to the fact that the presence of valves in the branches of the portal vein seems widely spread among mammals, he says: 'But only in individual species, as in the beasts of prey, do the valves possess great importance in connection with the circulation. In many species they are to be considered much more as rudimentary organs, which act either only in youth, as in men and perhaps the ape, and later in part or wholly disappear; or for the most part, as in the rabbit, are very imperfect.'"—*Boston Med. and Surg. Journal*, Oct. 25, 1888.

Decree Concerning Foreigners in France.

This decree, which has now been signed by the Minister of the Interior and the President of the Republic, and has already come into execution, contains some points of interest. It is required that every foreigner not domiciled in France, but who intends to make his residence in the country, shall, within fifteen days after his arrival, make the following declaration to the mayor of the place in which he wishes to reside. 1. His name, surname, and those of his father and mother. 2. His nationality. 3. Date and place of birth. 4. Place of former residence. 5. Means of existence. 6. Name, age, and nationality of his wife and children, if any. Documents must be shown to support his declaration. The declarations must be made, as far as Paris is concerned, to the Prefect of Police. Strangers at present residing in France, and not having a fixed residence (*non admis à domicile*), will be allowed a delay of one month to enable them to comply with the foregoing requirement. Infringements against these formalities will be punished by ordinary police penalties, without prejudice to the right of expulsion possessed by the Minister of the Interior.—*Medical Press and Circular*, Oct. 10, 1888.

Statistics of the Population of France.

The *Journal Officiel* has just issued the report on the population of France for last year, which will be found more or less interesting. 278,056 marriages, 899,333 births, and 842,797 deaths took place during the period, showing an increase in the population of 56,536 individuals, or 3,920 more than during the preceding year. In spite of the increase, however slight, it is noteworthy that there is a steady decrease (12,808 annually) in the births during the last seven years. Of the total number of births registered during the year, 73,854 were illegitimate, giving a proportion of over 8 per cent. of the whole. In the department of the Seine (Paris) the percentage reached the high figure of 25, while in that of Finisterre it sank to 2. With reference to the fecundity of marriages the result is deplorable. A hundred women under fifty years of age furnished to the population only sixteen children, that is to say, one birth takes place in every six households. The proportion of boys to girls is as 105 to 100, but the advantage is lost in the deaths, as more men than women die in the year (107 to 100). The average number of deaths per 1,000 for 1887 was 22.—*Medical Press and Circular*, October 10, 1888.

The Limits of Hearing.

In the *Glasgow Medical Journal*, August and September, 1888, Dr. J. Kerr Love communicates an elaborate inquiry into the limits of hearing. A summary of his paper is as follows:

1. Notes produced by 15 or 16 vibrations per second are the lowest which can be heard by the human ear. The difficulty of producing vibrations of sufficient amplitude to make such notes heard is great, but it is probable that sounds caused by a smaller number of vibrations are perceived as separate impulses and not as true musical sounds. Many ears cannot hear notes caused by less than 24 vibrations.

2. The most powerful very high notes are produced by very small tuning-forks, and by them a vibration number of over 40,000 has been heard by Dr. Preyer and a few other observers. Other and more convenient means for producing very high notes are Mr. Galton's whistle and the small open pipes which the author has described in this paper. These tests show that most ears can hear nothing when the vibration frequency is over 30,000 per second. Many are deaf to notes produced by more than 20,000, and some to notes of 15,000 vibrations; in a few cases deafness to notes of 5,200 or 5,500 vibrations has been recorded.

3. The least observable difference in pitch is for untrained or slightly trained ears difficult to state, but (exclusive of cases of tone-deafness) it may be put down as from 1-6 to 1-40 semitone. The ears of such trained musicians as violinists, tuners, and some pianists, can perceive with certainty a difference of 1-64 to 1-80 semitone. All observers, but especially the untrained, detect sharpened better than flattened intervals. Generally speaking, Weber's Law holds good for all but the highest and lowest parts of the musical scale.

4. No quite satisfactory test has yet been found for the distance at which a sound of constant intensity can be heard. Politzer's Acoumeter is the best and most convenient test, and is heard by normal ears in almost perfect stillness at a distance of 49½ or 52½ feet.

5. Cases of tone or note deafness (deafness to intervals of a whole tone or more) are very rare, but some well-authenticated instances have been recorded.

Syphilis and Diabetes.

An interesting case is recorded in the June number of the *Annales de Dermatologie*, by Le Monnier, of Flers, of a patient 50 years old, who for five months had been suffering with diabetes, and passing sugar in his urine to the extent of 2 to 2½ ounces per quart. His condition was becoming serious, and the symptoms were increasing in severity, when suddenly he developed a gumma of his pharynx, which subsequently ulcerated, proving the presence of a syphilitic taint of which the patient had previously denied all knowledge. From the time that the gumma was discovered the patient was treated with iodide of potassium. At the end of eight days there was great improvement in the local affection, and, remarkably enough, the amount of sugar in the urine had fallen to 405 grains per quart. The treatment was continued, and, after the lapse of three months, the ulceration of the pharynx had cicatrized and all trace of sugar in the urine had vanished. The author remarks that, although the occurrence of syphilitic diabetes has not been disputed by Fournier, Lécorché, and others, still the case is worthy of publication owing to the fact that the usual diabetic treatment yielded no definite relief, and that the complications and progress of the disease were immediately arrested as soon as antisyphilitic remedies had been administered, resulting in the cure of the patient.—*Medical Press and Circular*, Oct. 10, 1888.

Vegetable Cows.

Several natural orders of the vegetable kingdom include plants that are characterized by the secretion of a fluid closely resembling milk in appearance and consistency, and a familiar example of these is to be seen in our common milkweed (*Asclepias cornuti*), which is well known to everybody. In some plants this milky fluid is of the most venomous nature; in others it possesses active medicinal virtues; in others it yields a product (such as india-rubber and gutta-percha) of the highest importance to the arts and industries; and in others still it proves of value as a human aliment. Since the same general properties characterize the plants of each natural family it seems an anomaly that, in the same order, we should find the species of one genus producing a lactescent fluid of a highly poisonous nature, and those of another yielding one that is entirely innocuous. Yet such is often the case, and we have a striking example of it in the bread-fruit order, the *Artocarpaceæ*, which, on the one hand, includes the celebrated upas tree of Java, which, when pierced, exudes a milky juice containing an acrid virulent poison (antiarin), the smallest quantity of which will kill the largest animal; and, on the other, the famous *Brosimum utili* of South America, which yields a copious supply of rich, wholesome milk, of as good a quality as that from the cow. There are several other instances in the vegetable kingdom of such an association, in the same natural order, of plants that produce a noxious lactescent juice with others which yield a wholesome one adapted for man's use, and which may therefore be designated as "vegetable cows." To speak only of the latter class, the most remarkable example is the species of *Brosimum* just mentioned, which was discovered and made known by the celebrated traveler Humboldt. This tree forms extensive forests on the mountains near the town of Coriaco and elsewhere along the sea-coast of Venezuela, growing to upward of one hundred feet in height, with a trunk six or eight feet in diameter, and branchless for the first sixty or seventy feet of its height. It is popularly known as the cow-tree, *palo de vaca* or *arbol de leche*. Its milk, which is obtained by making incisions in the trunk, so closely resembles the milk of the cow, both in appearance and quality, that it is commonly used as an article of food by the inhabitants of the places where the tree is abundant. Unlike many other vegetable milks, it is perfectly wholesome and very nourishing.—*Scientific American.*

New Treatment for Dislocation of the Jaw.

In *L'Union Médicale* is an account of a sportsman, who, in calling to his dog, dislocated his jaw. With great difficulty he made his way to the nearest town, arriving late at night, and rang the bell of the first physician he could find. The doctor put his head out of the window and asked who was there. But the sufferer was unable to utter a word, and dismayed at the closing of the window, rang again, still more vigorously. The same scene was reënacted several times, until the doctor, thinking it a practical joke, stole downstairs, and opening the door suddenly, struck the patient full in the face and slammed the door. As soon as the patient recovered from his astonishment he found his jaw entirely in place, and calling out "thank you," he went on his way rejoicing.—*Northwestern Lancet*, Oct. 1, 1888.

Case of Delusional Insanity.

"Some months ago," says the *Sacramento Medical Times*, October, 1888, "a wealthy rancher of this county conducted himself in such a manner that his family became apprehensive for their safety, and decided to confine him in an asylum. His resentment was principally directed against his wife, a woman of excellent character, advanced in years, the mother of a large family, whom he accused of having had intercourse with some of the farm hands. He stated that on several occasions he was on the same bed on which these acts were perpetrated, but in a cataleptic condition, the result of chloroform which she had administered. The method of administration was interesting. She had placed a handkerchief, saturated with chloroform, in the pocket of a dress which hung four feet from the head of his bed. On these facts and much additional evidence, three physicians decided that he was a monomaniac and that it was unsafe for him to be at large. A jury was impaneled, and in the face of the medical testimony and overwhelming evidence furnished by the accused and his family, they acquitted him of the charge. The result was mainly due to the efforts of able counsel for the defense. The accused had numerous friends who firmly believed in his sanity, and regarding him as the victim of designing people, helped him with testimony and funds. One man in particular was earnest in his protests against the outrage sought to be perpetrated upon his friend. Several months after the trial he asked the victim to witness a will of which he was the executor; this was duly done. Subsequently the testator died and the will was contested, when the same man testified upon oath that he never signed or saw the will, denied his own signature, and positively accused his friend, the executor, of sequestrating $1000 of the funds involved. Many similar cases have, no doubt, occurred, and it is most desirable that they should be recorded as furnishing important evidence on the intricate subject of mental jurisprudence."

—Professor Sachs, of Würzburg, has been invited to the Chair of Botany in the University of Munich, lately occupied by Professor Nägeli.

—Professor Unverricht, of Jena, has been offered the Chair of Medicine in the University of Dorpat, made vacant by the resignation of Professor Schultze, who went to Bonn.

NEWS.

—Dr. Harrison Allen has moved to 1933 Chestnut St., Philadelphia.

—Dr. Robert R. Livingston died in Plattsmouth, Neb., Sept. 28, 1888.

—Dr. Galippe, a French dentist, declares that antipyrine blackens the teeth, especially when they have lost their enamel.

—Dr. Joseph O'Dwyer has been appointed Professor of Diseases of Children in the New York Post-graduate School and Hospital.

—The remains of Dr. Jacob Vreeland, formerly of Brooklyn, N. Y., were brought to New York City from England, October 2. Dr. Vreeland went abroad on a vacation last August, but died September 2, of pneumonia. He was 60 years of age.

—Dr. John B. Hamilton has been appointed Editor of the *Journal of the American Medical Association*, and it is said that he intends to resign his position as Supervising Surgeon-General of the Marine Hospital Service, in order to accept the appointment.

—Thirty-three new cases of yellow fever and five deaths were reported in Jacksonville, Fla., Nov. 10, 1888. The weather is said to be cool, but there has been no frost. New cases are also reported from Gainesville and Fernandina, Fla., and from Decatur, Alabama.

—The committee in charge of the annual banquet of the Ex-Resident Physicians of the Philadelphia Hospital, Blockley, announces that the banquet will be held December 4. The time and place have not yet been announced. The committee is very desirous of having the names and addresses of all Ex-Resident Physicians, and will be glad to hear from any upon this point. The Secretary is Edward R. Stone, M.D., 1539 N. Nineteenth Street, Philadelphia.

—The Paris correspondent of the *Lancet*, Oct. 27, 1888, says that at a recent meeting of the Academy of Sciences, Professor Bouchard communicated, in the name of MM. Charrin and Armand Ruffer, a work on the elimination with the urine of soluble vaccinal substances. The authors show that the soluble substances manufactured by the microbes can traverse the body of the animal and be eliminated with the urine, whilst still preserving their property of conferring immunity. The production of vaccinal matter should be attributed directly to the microbes, and not to the cells of the living organism.

—The latest report of the An Ting Men Missionary Hospital, in Pekin, says the *Ledger*, Nov. 12, 1888, contains some interesting information in regard to certain classes of Chinese patients. Suicides are very common in Pekin, a strong extract of opium being most commonly employed for the purpose, but stabbing with a knife in the abdomen is common. In one case of this kind, which was treated at the hospital, the reason assigned for the act was that the man had applied to a friend for a loan of money and been refused. In order to spite the niggard, he committed suicide, that his spirit might come back and perpetually annoy the latter. Possession by demons or animals is a complaint for which patients constantly demand treatment. The animals in question are most commonly the fox, weasel, hedgehog, snake and rat. Persons possessed of one or other of these are supposed to have extraordinary power in revealing future events, curing diseases, or indicating lucky days and numbers.

HUMOR.

BROWN—"You don't look well lately, Robinson." Robinson—"No; I can't sleep at night on account of lung trouble." Brown—"Nonsense; your lungs are all right!" Robinson—"Yes, mine are; the trouble is with the baby's."

EDITOR—"Uncle Rastus, we want another man at the office to help keep things in shape. Do you think you would like the job?" Uncle Rastus—"I reckon I wud, Mistah Shears; but I dun know. No man kin tell how he wud like editin' till he tries, sah."—*Harper's Bazar.*

WAS A BOY ONCE HIMSELF.—Boy—"Say, Mister, father wants to know what's the cheapest way of gettin' teeth inserted." Village dentist (significantly)—"Well, I reckon the cheapest way that I know is to come and steal my apples when my bull-dog's round."—*Harper's Young People.*

"THIS IS INDEED a hand-to-mouth existence," sighed the druggist, as he tore off and licked the postage stamp for a chance customer. "I'm also doing a light business," said the man at the cigar counter; "at least my gas jet seems to be the only thing wanted by half the men who come in."—*Puck.*

IN FINANCIAL DISTRESS.—Bobby's Uncle James had given him a penny to invest at the candy store, and he darted off filled with glad anticipation. Presently he returned, crying bitterly. "What's the matter, Bobby," inquired his Uncle James, "did you lose your penny?" "N-no, sir," sobbed Bobby, "t-taint lost, it's jest swallered."—*Epoch.*

A QUESTION OF LOCALITY.—"This is a very grave case, my man," said a doctor, leaning over a wounded man in a hospital. "Is it really dangerous, doctor?" "Very; you have been injured in the lumbar region." "Now that's just where you're mistaken. I was never in Maine in my life. I got this wound in the Blue Mountain region."—*Harper's Bazar.*

WHAT THE DOCTOR PRONOUNCED IT.—"What did the doctor pronounce your ailment?" inquired the wife, with a tremor of anxiety in her tone, as she came into her husband's sick-room. "He pronounced it as if it were spelled bronkeetus," exclaimed the indignant Bostonian, straightening himself up in bed, "and I requested him at once to make out his bill and go."—*Chicago Tribune.*

A CORONER'S VERDICT.—The following delicious coroner's verdict is in print, apparently a specimen of Baboo English, that is, English as written by a native of India. This was rendered upon an ill-fated Hindoo. "Pandoo died of the tiger eating him; there was no other cause of death. Nothing was left except some fingers, which probably belonged to the right or left hand."—*Boston Med. and Surg. Journal.*

SUSPECTED A TRAP.—"Here's an article headed: 'Mavelous Escape of a Distinguished Citizen from a Horrible Death,'" said the dutiful daughter, who was reading the morning paper to her invalid father. "'The friends of Mr. J. Alpheus Bramble were shocked on learning, a few mornings ago, that—'" "Jane," interrupted the irritable parent, "before you read any more of that you will oblige me if you'll look about half way down to the bottom of the article and see whose patent medicine it's advertising."

MARRIAGES.

THEISS—MANTON.—On Sept. 25, 1888, by Rev. J. H. Conkle, H. C. Theiss, M.D., to Miss Eva Manton, both of Akron, Summit Co., Ohio.

MECASKEY—MARTIN.—On Oct. 18th, at Albion, Mich., by the Rev. J. C. Floyd, Dr. J. W. Mecaskey, of Phila., to Mary Katherine, daughter of Dr. R. A. and Mrs. Isabella Martin.